Consolidating and Strengthening a Decentralised Pre Service Training and Continuing Education System for the Health Sector in Tanzania

Revised Proposal
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Acronyms

ARV	Anti-Retro-Viral
CE	Continuing Education
CHMT	Council Health Management Teams
CPD	Continuing Professional Development
CO	Clinical Officer
DHR	Directorate of Human Resources
DMO	District Medical Officers
GoT	Government of Tanzania
HA	Health Assistant
HEAC	Higher Education Accreditation Council
HMIS	Health Management Information System
HMT	Hospital Management Team
HR	Human Resources
HRD	Human Resource Development
HRH	Human resources for Health
HRM	Human Resource Management
HRMIS	Human resources Management Information System
HTEI	Higher and Technical Training Institutions
HTI	Health Training Institution(s)
HMT	Hospital Management Team
HSR	Health Sector Reforms
HSSP	Health Sector Strategic Plan
HW	Health worker
ICT	Information and Communication Technology
IFMIS	Integrated Financial Management Information System
LG	Local Government
LGA	Local Government Authority
LGR	Local Government Reforms
MCHA	Mother and Child Health Aids
MOH	Ministry of Health
MOH-HQ	Ministry of Health Head Quarters
MSTHE	Ministry of Science and Technology and Higher Education
MTEF	Mid-term Expenditure Framework
MTs	Management Teams (CHMTs, RHMTs, HMTs)
M&E	Monitoring and Evaluation
NACTE	National Council for Technical Education
NGO	Non-Governmental Organisation
OD	Organisational Development
OPRAS	Open Performance Review and Appraisal System
OR	Operational Research
PHC	Primary Health Care
PHCI	Primary Health Care Institute
PORALG	President's Office Regional Administration and Local Government
PRS	Poverty Reduction Strategy
PSM	Public Service Management
PSR	Public Service Reforms
PST	Pre-service Training
PSS	Public Service Scheme
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team
RMA	Rural medical Aid
QA	Quality Assurance

QC	Quality Control
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
SWAP	Sector-wide Approach
TI	Training Institution
TMIS	Training Management Information System
TNA	Training Needs Assessment
ToT	Training of Trainers
TSHS	Tanzanian Shillings
VA	Voluntary Agencies
WHO	World Health Organisation
ZHTI	Zonal Health Training Institute
ZTC	Zonal Training Centre

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Executive summary

Consolidating and Strengthening Pre-Service Training and Continuing Education in Tanzania

Introduction

The goal of the consultancy is to produce a funding proposal that describes a midterm plan for establishing an improved, sustainable, decentralised and linked Pre Service Training (PST) and Continuing Education (CE) system for health, concentrating on the role and functions of Zonal Training Centres (ZTCs) in this change process. Through a process of participatory analysis and consultation with stakeholders in the health sector, education sector, local authorities and public service, the consultants have developed this proposal. The proposal plans for a three-year programme of consolidation and strengthening the PST and CE system.

In the document, the terminology used is in line with the practice in Tanzania: pre-service training for new entrants into the health system; in-service training for upgrading of staff in the health sector through formal training programmes, and on-the-job training for updating knowledge and skills of staff through informal training activities within the district health services or health facilities.

The Context

Human Resources Development is just one factor in the complexity of factors influencing supply and demand of human resources in health. On the demand side health service needs (e.g. based on utilisation and the expansion of the infrastructure), technological developments (e.g. introduction of Anti-Retro Viral (ARV) Therapy) are some of the important factors. On the supply side type of training, numbers of output of newly trained workers and turn-over of staff are important factors. Expansion of the private sector in health is a relatively new development in Tanzania, having a bearing on Human Resources Development (HRD) in health.

However, factors outside the health sector are as important as within the health sector. The Sub-Master Plan for tertiary education will have an impact on training in health, leading to rationalisation and decentralisation of higher and technical education institutions. The National Accreditation Council for Technical Education (NACTE) and the Higher Education Accreditation Council (HEAC) will have functions of accreditation of institutions and validation of training programmes. Furthermore, the Government programmes of decentralisation, especially devolution to local authorities, are of importance as well as the Public Service Reforms, affecting all public servants. Overriding all reforms are the socio-economic developments in Tanzania, which determine availability of human capital and finances for the health sector.

Internationally, developments in the East Africa Community and SADCC should be mentioned, which call for further harmonisation and international standardisation of curricula and registration requirements for professionals.

There is a need to update the HRD policy of the Ministry of Health (MOH) and to initiate a change programme in the Human Resources for Health (HRH) training sector. It is necessary to harmonise pieces of legislation, regulations and policies in the health and education sector. Further collaboration within the MOH, between the HR department and other departments, units and programmes is necessary to materialise the harmonised policies.

Situation Analysis of training in health

The consultancy performed an analysis of the steps involved in training, ranging from pre-training activities, to implementation and post-training evaluation and impact assessment.

The MOH has the responsibility to perform the needs assessment for HRH in the whole sector, which is a huge task, compounded by the lack of a proper HRH information system. The type of training and the numbers of students to be trained in the training programmes should be determined by the needs of the health system.

Within devolved district health services and health facilities a new open performance review and appraisal system (OPRAS) has been introduced under the Public Service Reforms (PSR), which incorporates training needs assessment. However, a more personalised assessment of needs for updating knowledge of skills – related to actual performance gaps – is used on a limited scale.

Information on available options for training is not widely available for health workers or the general public. The selection of candidates for formal training programmes is still highly

centralised within MOH-HQ and often regarded as not transparent. In this process, the needs of the health services organisations play a minimal role. Vertical programmes continue to play an important role in selection of candidates for the on-the-job training programmes these programmes offer. In training there is wastage because of under-utilisation of training institutions, training wrong people for the wrong courses, and duplication.

The responsibility for curriculum development and review is with the MOH-HQ. There is no clarity on the extent to which training institutions can develop their own programmes and the incorporation of new developments in health sciences is considered too slow. The quality of informal training activities at the local level is not always guaranteed.

With regard to the quality assurance of training, NACTE is in the process of formulating the standards for Health Training Institutions (HTI), but sometimes these activities overlap with work of the Nurses and Midwives Council. There is room for improved coordination in this area.

There is no systematic measuring of impact of training on service delivery and feed back to the training institutions is missing. Also the longer term effects of on-the-job training are not well-known.

With regard to the institutional arrangements, there is a big difference between private institutions and government institutions. The private institutions have their own staffing, budget, finances, select their own candidates, determine their own fees, etc. Government institutions are highly dependent on MOH-HQ. Staff is directly under the ministry; the MOH determines the budget, the subventions, selects candidates and determines the cost-sharing fees for students. Also the content of the formal training programmes offered in the institutions is determined by the MOH.

Situation analysis of Zonal Training Centres

Zonal Training Centres (ZTCs) are unique institutions in the health sector. They are more or less virtual institutions. They do not have an establishment and no staffing (but they make use of staff in health training institutions); the ZTCs have no budget, apart from money provided by the MOH HR department. Legally, they are directly under the MOH-HQ. In practice, the activities of the ZTCs are intertwined with the activities of the training institutions where the ZTC is based. Cedha-Arusha and PHC-Iringa are more oriented towards CE than other institutions, where ZTCs are based, and have a much larger resource base than others, in terms of staffing, equipment and infrastructure. These two institutions attract more donor funding, generate their own income and have some informal autonomy. Their levels of activities as ZTCs are therefore much higher than other, less resourced, institutions.

ZTCs have been involved in training needs assessment, curriculum development for CE, on-the-job training, supervision of training institutions, etc. ZTCs have developed health learning materials, provided information on training to health services and have provided follow-up on training activities. However, the activities were always dependent on external funding, and never sustained over a long period of time.

The MOH sees consolidation and strengthening of ZTCs as an important step towards improved HRD in the country, because the ZTCs have proved their value, when sufficiently resourced.

Vision for consolidation and strengthening PST and CE system

The vision is to have 8 Zonal health training institutes (ZHTIs), which are providing the whole range of pre-service training, in-service training and on-the-job training. New Zones will be created in South-West (Mbeya) and Central (Dodoma). The Zonal health training institutes will operate from multiple locations and will incorporate the existing training schools. Each institute will have at the Zonal level a directorate with an administration, a quality assurance unit and a resources centre. The Zonal directorate is responsible for accreditation with NACTE. The four departments are pre-service training, continuing professional development (with in-service and on-the-job training), HRD support, and research and consultancy. Besides delivering training, the institutes will provide information on training and HRD to stakeholders, will co-ordinate and liaise between the periphery and the centre, and will provide support to management teams in the implementation of HRD (career development plans, training needs assessments, etc.) The ZHTIs will certify on-the-job training courses, within the context of CPD, for re-registration of health professionals. There will be intensive networking (using ICT) between the ZHTIs and with the MOH-HQ.

The ZHTIs will be semi-autonomous, maintaining relations with the MOH-HRD dept, which will be rationalised. ZHTIs will also maintain direct relations with the programmes in MOH.

The training institutions need more resources, including human resources (a core staff and support staff), finances, a suitable infrastructure and access to internet.
The emphasis will be on achieving an economy of scale, concentrating on innovating in teaching methodologies and quality of training programmes, resulting in more client-oriented services.

Elements of consolidation and strengthening PST and CE

The consultancy also provides suggestions for change affecting other organisations in the health sector. The document provides suggestion for redefining roles and responsibilities in HRD in health: the decentralised health services (Council health services and hospitals) can play a bigger role in training needs assessment and selection of candidates for training. ZTCs can provide technical support in the area.
Training institutions can take greater responsibility for curriculum development and planning of training programmes.
With regard to on-the-job training the Council Health Management Teams (CHMT) and where applicable the Regional Health Management Teams (RHMT) are the responsible parties. National health programmes should work through the ZHTIs, not independently. Better planning of on-the-job training, through the Comprehensive Council Health Plans, is necessary.
New institutional arrangements will have to be made, with more responsibilities for decentralised health providers, more autonomy for health training institutions and a limited role for the central MOH. Policy making, overall planning, resource mobilisation and quality control remain functions of the MOH.

Steps in the change process

This consultancy has formulated a three-year plan which should result in a stronger system for providing PST and CE.
It will start with adoption (and refining the vision), creating a steering committee and stakeholders consultation and motivation. It has four strategic components and one enabling component.
First of all, further harmonisation of the legislation, regulations and policies is proposed, both within the health sector and in relation to the education reforms and public service reforms. This should result in a new HRD policy for the MOH in Tanzania.
Secondly, a framework has to be formulated for implementation of the HRD policy, not only a strategic plan has to be produced, but also the interdisciplinary consultation processes have to be created, capacity building activities have to be planned, etc.
Next is the redefinition of roles and responsibilities, whereby further decentralisation and further quality improvement are key issues to be addressed. New institutional arrangements, in line with the education reforms and in line with the desire to decentralise, have to be formulated and implemented. Finally, a monitoring system has to be put in place, which allows for steering and reviewing the process.
Important in the process is the production of comprehensive business plans, which will also guide the necessary investments in infrastructure, equipment and human resources.
The logical frame work for the three years' plan is attached to this report.

Next steps

Establishing ZHTIs is a process, which can start relatively easy with some "quick wins", while more fundamental changes are prepared. Establishing resource centres and internet connections is relatively easy. Some of the proposed functions have been implemented by (some of) the ZTCs in the past, though only in a project mode. With a relatively small number of staff and with some funds for running costs, the ZTCs can made to function much better. ZTCs can revive supervision to HTIs, follow-up on training courses, intensify distance learning programmes, etc. The ZTCs can be used better for national on-the-job training programmes, like IMCI, district capacity building, dissemination and scale up of TEHIP tools, etc. Thus, the ZTCs can play an important role as catalysts in the total change process needed in pre-service training and continuing education.
A budget outline for the change process of PST and CE is attached, as well as a budget for strengthening the ZTCs while transforming into ZHTIs.

1 Introduction

1.1 Goal of the consultancy and approach

The Terms of Reference for this consultancy have formulated the following goal:

> "To produce a funding proposal that describes a midterm plan for establishing an improved, sustainable, decentralised and linked Pre Service Training (PST) and Continuing Education (CE) system for health, *concentrating on the role and functions of Zonal Training Centres (ZTCs)*[1], that will contribute significantly to improve overall quality and the strengthening of the district health system and coverage of essential health services delivery in Tanzania."

Based on a procedure of competitive bidding, the consortium of Public Health Consultants/ Interaction in Health, Liverpool Associates in Tropical Health and TRACE was awarded the assignment. In its proposal the consortium outlined the process that it would adopt in this consultancy. The emphasis in the whole process is on participatory analysis and planning.

The consultants carried out a document study and held interviews in August and September 2004 and subsequently produced an Issues Paper with an analysis of critical issues. A first national round table conference with key stakeholders on 8 October 2004, reviewed the present state of developments around PST and CE. Field visits were then conducted in all six ZTCs and in four areas around ZTCs. Four Zonal conferences were organised to collect the views of stakeholders at the local levels. The second national conference discussed the options, focused on the roles and functions of the ZTCs, for further development of PST and CE that were generated during the Zonal conferences.
After submission of the final report, the MOH organised a stakeholders meeting on 28 February and 1 March to discuss the proposal, and update it in the light of new developments. This has resulted in the revision of chapter 5 – 10 of this report
This document outlines a plan and budget for strengthening the system for providing PST and CE, and proposes the creation of Zonal Health Training Institutes. The document tries as much as possible to reflect the consensus built during the consultative process.

1.2 Terminology

Some of the terminology used in this document may need clarification to avoid misunderstanding.

Pre-service training
Pre-service training (PST) in the health sector provides medical or para-medical (also called allied) training programmes. There are no specific training programmes in management or administration in health. The Ministry of Health is in the process of rationalising the number of different cadres. This has implications for the training programmes, especially those that were being provided for lower-level cadres that are being phased out. PST takes place in institutions under the Ministry of Health, the Ministry of Science and Technology Higher Education (MSTHE) and in private (mostly church-related) training institutions.

[1] The phrase in italic added in agreement with the steering committee for this assignment after the inception of the consultancy.

Continuing Education
Continuing Education (CE) in Tanzania can be divided into two elements:

a. Formal (advanced) in-service training leading to qualifications (generally less than two years). This kind of continuing education is mostly used for the career advancement of the individual. For those in cadres that are being phased out (MCHA, RMA, HA), upgrading courses in this category are essential to enable them to continue in employment. Training institutions are under the MOH, under MHEST or private institutions.
b. On-the-job training (workshops, seminars, meetings, short refresher courses, etc) is generally organised by the departments of the MOH or at the local level by CHMTs. It is mainly for updating the knowledge and skills of health workers and maintaining their competencies, and does not contribute specifically to the career advancement of the individual.

Continuing Professional Development
Where CE is used in a systematic way to develop the skills and careers of the individual, it is often referred to as Continuing Professional Development (CPD). This refers to the continuing development of the multi-faceted competencies inherent in (para)medical practice, covering wider domains of professionalism (e.g. medical, managerial, social and personal subjects) needed for high quality professional performance. Although CPD designates the period commencing after completion of training, CPD has much further ramifications. CPD activities have a basis in the life-long continuing learning process. The shaping, reshaping and development of a professional involves responding to changing societal and individual needs, in the context of evolving medical science and health care delivery. Independence also is implied: CPD activities being characterised by self-directed learning, only rarely involving supervised training for any extended period of time.

In this document the term **CHMT** (Council Health Management Team) is used for the management team working under the District Medical Officer in the Councils. The **RHMT** (Regional Health Management Team) consists of the Regional Medical Officer, who is part of the Regional Administration (RA) and co-opted members from the regional hospital, performing tasks of supervision and support to district health services. The **HMTs** (hospital management teams) are in charge of regional and referral hospitals. The regional hospitals report to the Regional Administrative Secretary and the referral hospitals to the MOH (but will become autonomous). In this report the CHMTs, RHMTs and HMTs together are captured under the acronym **MTs**.

1.3 Document overview

This document continues with a discussion of the analytic framework, drawing on a framework developed by World Health Organisation (WHO), which presents Human Resources Development as one element in the system of supply and demand of human resources for health. This is followed in Section 3 by an analysis of the policy context, within the health sector and the general government policy context. In Section 4, the functions of the training system are examined and the current roles, functions and institutional arrangements in HRD are analysed.

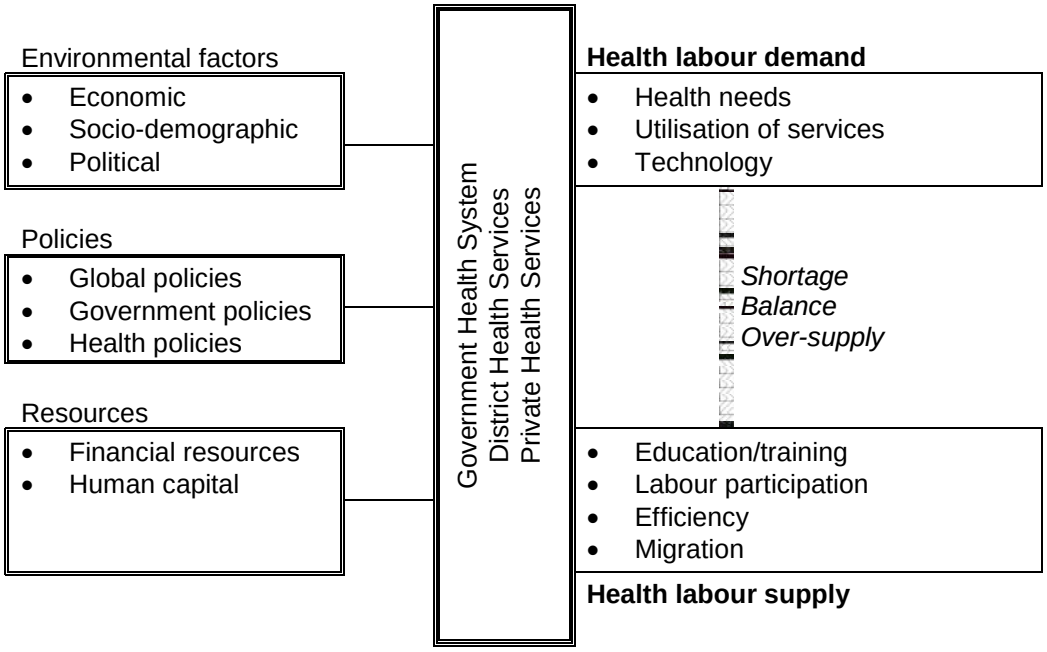
In Section 5 a plan is outlined for consolidating and strengthening the PST and CE system, followed by concrete proposals for changes in the roles and functions and institutional arrangements in Section 6. In the subsequent sections 7 – 9, the change management process, the risks and assumptions associated with the changes and proposed monitoring and evaluation systems are discussed. In the final Section 10 a budget for this change programme is presented. The Annex contains the logical framework for the plan.

2 Analytic Framework for Human Resources Development

Human resources are being recognised worldwide as the most important factor in effective health care delivery. The HRH literature now emphasises the importance a more comprehensive analysis of HR issues in the search for appropriate solutions[2]. A particular concern is the identification of factors determining the supply and demand for health labour.

The analytic framework below was produced by a WHO technical consultation in Canada (WHO, 2002). On the demand side of human resources, the identification of health needs, the rising level of health care utilisation and the generation of new technologies are major factors. On the supply side of human resources, the main components are the patterns of education and training; labour participation of e.g. women and basic education levels; barriers to entry driven by regulation; and competition by regional or international migration of the health workforce.
In the view of the WHO the health labour market is part of the health care system and is generally characterised by market failures.

Figure 1: WHO analytic frame work matrix



As the model indicates training/education is just one element in the complicated system of supply and demand of human resources for health. Training/education plans need to be integrated with other strategies for balancing supply and demand and for developing a high performing workforce. In addition, all HR strategies need to be considered in a wider context: the environmental factors, policies and resources as well as government and non-government health systems.
The consultants did not study the wider context of human resources in health in Tanzania, as this was not part of the assignment, but acknowledge the importance of the factors contributing to adequate supply of human resources.

[2] See Martinez, J. and T. Martineau (1998). "Rethinking human resources: an agenda for the millennium." Health Policy Plan **13**(4): 345-58. and Egger, D., D. Lipson, et al. (2000). Achieving the right balance: the role of policy-making processes in managing human resources for health problems. Issues in health services delivery. Human Resources for Health. Discussion paper no. 2. Geneva, World Health Organisation

Two key external processes, influencing HRD in health in Tanzania, are the decentralisation process, which includes elements of devolution and deconcentration; and the introduction of market mechanisms in health and education.
In order to understand the challenges in HRD in health, the plan needs to address both the macro-level of the political, socio-demographic and economic developments in Tanzania and a micro-level of the capacities and needs of the HRD system.

In the analysis, the consultants follow the WHO model, specifically for the HRD aspects. Section 3 addresses the macro-level policy context and section 4 discusses the micro-level functions in HRD. These sections will closely follow this analytic model.

In carrying out an analysis of the training system, the consultants developed a list of the key functions of such a system (cf. the management cycle):

1. Pre-implementation activities
    - Assessment of training needs
    - Provision of information about training
    - Selection of training entrants
2. Delivery of training
    - Planning of training programmes
    - Curriculum development and revision
    - Commissioning and delivering training
    - Quality assurance and control of training
3. Post-training activities
    - Examinations
    - Monitoring of outcomes in practice
    - Evaluation of training

This model is used in the analysis (chapter 4), and in the proposal (chapter 5).

3 Policy context of HRD in Health

Within the health sector there are many existing and evolving policies, laws and regulations that will impact on and influence HRD developments. The extents to which key policies, legislation and regulations are or could influence HRD are discussed below.

3.1 External Environment

3.1.1 Decentralisation Policy

The decentralisation by devolution strategy is guiding Public Sector Reforms and Local Government Reform processes. As a result of these processes power and responsibility for the implementation and delivery of health services is being transferred from central level to local government authorities. The implications for HRM/D are that the district level (CHMTs) will assume greater responsibility for the management and financing of key elements of the training system. The annual district health planning process is being strengthened to plan for integrated health services, including HRD. The same applies to Hospital Management Teams.

The role of the central Ministry of Health under the decentralisation process (as outlined by the National Health Policy 2002) is policy formulation and coordination. Consequently, the MOH has the responsibility to ensure that HRD policies, strategic frameworks, guidelines and standards are in place to promote and direct strategic, integrated and coordinated approaches to HRM/D, and to ensure that delegated functions are effectively managed and undertaken.

3.1.2 Human Capital in Tanzania

The building of human capital to promote national development is seen as critical by the Government of Tanzania (GoT), for example in the Poverty Reduction Strategy Paper. The GoT recognises that a robust education system is needed, especially in higher and technical education, which can supply the critical human resources needed for effective social, economic and technological development. This prioritisation of human capacity development is reflected in the Government's budgetary allocation, with education and training accounting for over 25% of all public expenditure.

Overall government policy is being shaped by the trend towards globalisation and liberalisation; this implies a weakening of direct state control and a move towards an environment led by market and customer demand. This is the essence of devolution and decentralisation, giving decision making to enterprises, institutions and households.

In a liberalised economy the policy thrust on education and training tends to focus on three areas, financing, content and delivery. In the Tanzania context this implies:

- *Financing:* the need to provide incentives for efficiency and effectiveness based on enrolments in order to encourage responsiveness to demand, expansion, access, equity and choice;
- *Content:* new and revised curricula to be produced;
- *Delivery:* need to emphasise institutional and personal autonomy, diversification of supply, including private supplies and providers, promotion of competition and diversification of delivery modes.

In Tanzania there are currently several reform processes being undertaken simultaneously and therefore it is critical that issues relating to human resources for health are not addressed in isolation. Developments in the area of HRD in health need to be considered within the general policy context of devolution and decentralisation.

3.1.3 Education Reform

In 2003, the Ministry of Science, Technology and Higher Education (MSTHE), with support from the World Bank commissioned various studies to examine the efficiency, effectiveness and relevance of post secondary non-university tertiary education in Tanzania. The findings of these studies informed the development of Science and Technology and Higher and Technical Education Sub-Master Plans (2003-2018), which outline the components of the strategic and legal framework which will guide and direct the development and strengthening of these sub-sectors. The plans present strategies for institutional rationalisation, quality revitalisation and improvement, and institutional capacity strengthening of Higher and Technical Education Institutions (HTEI). This Sub-Master Plan also affects training institutions, which are under the line ministries, like the MOH.
The MOH has approximately 103 training institutions, 52 of which are tertiary institutions and as a result many of its training institutions will be affected by the implementation of these plans. It is essential that the health sector remains abreast of developments in the education sector and ensures that they are addressed in HRD policies, strategies and plans. The most relevant components of the Sub-Master Plans are: institutional rationalisation; quality revitalisation and improvement; and institutional capacity strengthening.

Institutional rationalisation
Planned to commence in 2005, the institutional rationalisation aims to improve the efficiency, effectiveness and quality of all training institutions. These rationalisation initiatives will have an impact on the operations, and the functional and organisational arrangements of health training institutions and on the overall HRD system. The Higher and Technical Education Sub-Master Plan identifies a number of weaknesses and constraints of the current training delivery mechanisms, which the rationalisation process intends to address. These include:

- Proliferation of institutions
- Low student-staff ratios
- Duplication and overlap
- Lack of regulation, coordination and QA/QC
- Proliferation of quality control mechanisms
- Survival tactics distorting original mission of institutions
- Low enrolment rates (linked to affordability, access, equity)
- Limited financial data and consideration of cost effectiveness
- Ability of the delivery mechanisms to meet labour market demands

Quality revitalisation and improvement
In its efforts to revitalise and improve the quality of education and training, statutory bodies such as National Council for Technical Education (NACTE) and Higher Education Accreditation Council (HEAC) have been established with a legal mandate to register, validate and accredit all training institutions (public, private and Voluntary Agencies), programmes and examining procedures. NACTE is responsible for registration and accreditation of training institutions and programmes (public and private) below graduate level, while the Higher Education Accreditation Council is responsible for graduate programmes. The responsibilities of both bodies include

assessment of staffing, teaching methodology, curricula development and examinations and assessment procedures.

The health training institutions will need to meet the quality standards set by these bodies in order to continue functioning in their current capacity. The National Health Policy indicates that the HRD Directorate is responsible for overseeing the quality of training, registration and re-certification through collaboration with health professional associations, owners of private health training institutions, the National Accreditation Council of Technical Education and other stakeholders. However, it is unclear how this process is managed collaboratively, what mechanisms are currently used to assure quality and how these are contributing to training quality, registration and re-certification that is acceptable and recognised by all parties.

The Nursing Council is also playing an active role in the validation and accreditation of nurse training institutions, programmes and nurse practice. The Nursing Council is mandated under the 1997 Act to register, set standards and conditions for nurse training institutions, to approve and review nursing curricula, and approve exams. The Nursing Council is currently introducing a new system of registration and licensing for individuals (nurses/midwives) and nurse training institutions. From 2004, it plans to renew registration and licences every 2 years and will be developing assessment guidelines and criteria for this re-registration process. It is unclear how the mandate and role of the Nursing Council fits with that of NACTE and how both bodies will ensure that regulations and assessment systems are harmonised and aligned. The capacity of the Nursing Council, as well as the capacity of NACTE may be insufficient to enforce compliance with new regulations.

While there is evidence of collaboration between NACTE and the MOH at the senior management levels, there is a need to ensure that the progress and outcomes of inter-sectoral collaboration is communicated to the relevant stakeholders and that functioning mechanisms are in place to ensure that HRD developments in the health sector are adequately informed by such outcomes. It is essential that MOH and Nursing Council roles and practices related to accreditation and quality assurance requirements and regulations are neither being duplicated by nor are in conflict with those of NACTE.

An example of the complexity and inflexibility of the diverse accreditation arrangements in place is the current impasse on qualifications for particular MOH approved training programmes being accredited by the relevant bodies (e.g. distance education courses for upgrading MCHA to Public Health Nurse B). It is critical that all of these bodies effectively collaborate to synthesise and harmonise systems, procedures and processes in order to ensure that quality improvement efforts are integrated and coordinated, that they have the intended impact of strengthening and improving the overall training system and particularly that the time, effort and investments made in training are not wasted.

Institutional capacity strengthening

The Higher and Technical Education Sub-Master Plan also proposes the decentralisation of authority and autonomy in decision making to boards and councils by the end of 2004. Institutional governing boards/councils will be established to oversee the implementation of institutional strategic plans. To date, none of the health training institutions have been granted autonomous status although various MOH policies and strategies (i.e. hospital reform guidelines, HRD policy and HSSP) indicate that this is a planned initiative. It is important that Health Sector plans and processes for the new institutional arrangements are aligned with those of the Education sector to

ensure that the established arrangements are sustainable and acceptable to all stakeholders involved in training and development.

3.1.4 Public Service Management

The Ministry of Health, in addition to other government ministries, departments and agencies, is bound by the Public Service Act, Public Service Regulations and Public Service Scheme. In relation to HRD, the Public Service Regulations stipulate that it is the employer's responsibility to provide CE opportunities for staff, but as there are no further guidelines on this area it is unclear how Public Sector Management will enforce and monitor this. Nor is it clear the extent to which the MOH, and the local government authorities as the main employers of health workers, can meet this responsibility using the current mechanisms of the training systems.

The Public Service Scheme also prescribes the career and professional advancement paths for all public servants, including health workers. The training and development of health workers will need to be aligned with these regulations; training programmes and qualifications awarded by MOH training institutions should fit with these pathways and be linked to health worker increments and promotion opportunities. To achieve this, the MOH may need to be more proactive in negotiating for the inclusion and recognition of MOH qualifications and programmes in the Public Service Scheme. However, to justify their inclusion these programmes and qualifications will need to be assessed and quality assured by systems and procedures that are acceptable and appropriate to accreditation bodies such as NACTE.

3.1.5 Fiscal decentralisation

Further fiscal decentralisation is planned with the introduction of a system of formula based recurrent grants (PORALG, 2004). This will replace the current system of negotiated budget allocations for local governments with a formula-based system, where the level of grants that each LGA receives are demand driven, based on a number of client-focused financial norms. It is anticipated that over time all donor funded Area Based Programmes, Basket Funds and other sectoral programmes will be converted into budget support and allocated through this system. The implementation and application of this system should support the further integration of vertical programmes into the devolved health systems. However, this new system may have implications for those donors unable to provide budgetary support, who may as a result be forced to work outside sectoral coordination arrangements.
At this moment in time, it is not possible to anticipate what this will mean for donor funding of training institutions in the health sector.

3.1.6 Private Sector

The global trend is for governments to withdraw from direct management of managing economies and institutions and to provide greater autonomy and rely more on market forces, i.e. granting of autonomous status for institutions.

Part of the Government's overall reform process is to liberalise the economy and this includes increased freedom for the private sector to operate in all areas. It is the Government's new role, in addition to being a player, to concentrate on the creation of an enabling environment for private initiatives. The main aim of public sector reforms is to reduce the government's role in service delivery and create more competitive markets. Local government reforms are promoting decentralisation and better value for money for the provision of services.

The effect of these trends for the HRD system is the gradual removal of Government from direct management of training institutions and reliance on greater market forces, which may lead to a growth in private training institutions and greater cost sharing in all training institutions. There is the potential for the private sector to play a greater role in the provision of health worker training but effecting this will require improved access to adequate capital and a more beneficial and conducive institutional framework. However, the current situation of high dependence on funding from development partners for capital investment may constrain this.

Private sector involvement in training can be promoted in two main areas; through strengthening the role of private and private-not-for-profit training institutions in the delivery of training; and by promoting the role of private health facilities in the consumption of trained health workers (and contributing more towards funding training institutions). It is Government policy to explore mechanisms for these different modes of collaboration and partnerships.

3.1.7 Development partners

Development partners in general have demonstrated their commitment to integration and decentralisation, with the majority having adopted SWAp mechanisms for sectoral support. However, some continue to fund area based programmes and national health programmes such as HIV/AIDS, TB, Reproductive and Child Health, malaria and other preventive programmes. Some of the development partners are looking for options to integrate training elements of national health programmes into regular training programmes, but others are isolating the programmes they are funding from the mainstream activities in the health sector, which may inhibit the development and implementation of integrated and coordinated approaches to HRD for health.
Within the MOH-HQ there is no unanimity on the approach towards development partners who advocate isolation of training activities.

3.1.8 International and Regional arrangements

The globalisation of the labour market for health sector workers is increasingly having an impact on Tanzania. This will further increase as previously national specific cadres of staff, e.g. MCHA, are being upgraded to regionally and internationally recognised cadres. Also there are ongoing developments in creating a regional awarding body for East Africa, similar to other regional awarding bodies. The formation of the East African Community and the Southern Africa Development Community have created regional blocks that promote the mobility of capital and this will include a recognised labour force to allow for this mobility. Within the East African Community, medical schools are already harmonising their curricula, to reinstate the mutual recognition of degrees.

Under these regional political and economic alliances tertiary education has to meet national, regional and internationals levels of quality. Tanzania is an active member of many regional and international organisations and forums and is committed to competent human resources that are also recognised by the ‘outside’ as such.

Currently in many countries it is the practice that all professional cadres need, as part of their re-registration process, to demonstrate the extent to which they are maintaining their continuing professional development (CPD). In some countries this has meant that health workers are expected to attend a certain number of days continuing education (CE) training per annum, though the type, quality and application of the CE training received is rarely evaluated to ensure that it does contribute to the health

workers CPD. Within the East Africa Community, CPD is on the agenda. Uganda has already introduced the system for medical practitioners. Recently the Medical Associations of Kenya, Tanzania and Uganda reconfirmed the intention to come to mandatory CPD and urged the Ministries of Health to collaborate in this undertaking.[3] If such a system was to be introduced in Tanzania then it would need appropriate mechanisms for awarding points for different types of training (seminars, on-the-job training, etc,) and for evaluating and measuring the benefits of the training both in terms of improved individual and sector performance.

3.2 Policy context within the MOH

3.2.1 Health Sector Reforms

There are nine strategies identified in Health Sector Reform Programme, one of which addresses the strengthening of HRH. Currently there is a functioning multisectoral HRH Task force that is addressing key HRH issues. There has been limited implementation of the Hospital Reform Programme, but the guidelines indicate that the Hospitals will be given semi-autonomous status and as such be responsible for the management of training and development initiatives for their health workers.

3.2.2 National Health Policy 2002

The National Health Policy provides the strategic framework and direction for the assumption of new roles and responsibilities within a decentralised health system. It identifies the new role of the central ministry as policy formulation and quality assurance. It also identifies the HRD Directorate as responsible for overseeing the quality of training, registration and re-certification through collaboration with health professional associations, owners of private health training institutions, the national council of Technical Education and other stakeholders. It will be important to ensure that the role of the MOH in training is confined to monitoring and coordination and that the implementation role is delegated to the CHMTs at the council level, and other relevant health institutions.

3.2.3 Health Sector Strategic Plan 2003-08

The HSSP prioritises the following in the area of HRD:

- Decentralisation of training to ZTCs
- Analysis of skills and HR needs at district level and TNA undertaken at regional level in collaboration with ZTCs
- District in-service training plans developed by districts
- ZTC networking to develop training modules
- Continuing integration of vertical programmes and activities in comprehensive district plans
- Continued exploration of options for the enforcement of accreditation of health institutions
- Health training institutions improved in line with institutional strategic plans

3.2.4 Health Services Draft Bill

[3] Third East African Continuing Professional Development (CPD) Consultation, Royal Palm Hotel, Dar-es-Salaam, Tanzania, 28th & 29th October 2004.

The new health services act will provide the legal framework for institutional arrangements within the health sector. The text of the draft was not available for review during the consultancy.

3.2.5 Strategic Plan for Integration of Health Services

The MOH has produced a strategic plan for integration of health services (MOH, 2002), which contains a situation analysis and proposals for further study, e.g. into integration of training activities. It is unclear the extent to which the strategic plan has been operationalised. MOH and donors remain 'committed' to the integration of health services, but the vertical programmes continue to be centrally managed and training for these programmes is not included in the Comprehensive District Health Plans. .

3.2.6 MOH structures and organisation

Strategic direction for the sector is informed by Health Sector Reforms, Hospital Reform Programme, Health Sector Strategic Plan, PRS, Strategic Plan for Integration of Health Services. However, it is unclear the extent to which these have been harmonised and communicated to all staff so that each of the departments and Units are contributing to the achievement of health sector goals . Departments within the MOH such as Preventive Services, Policy and Planning, Health Reform Secretariat and HRD all have a role to play in the strengthening of integrated and coordinated approaches to HRD.

3.2.7 Human Resource needs for the health sector

In the MOH-HQ the HR planning unit, is tasked to undertake assessment at the macro level in terms of staffing levels, needed in-flow, through-flow and out-flow. The MOH needs to be able to determine the cadres and quantities needed for the effective delivery of quality health services. Data suggests that the size of the health workforce has declined by 20% over the past ten years (mainly administrative and lower trained cadres) (Kurowski et al, 2003). A deployment database as recommended by the Health Sector Review (1999) was completed in October 2003 and outputs of the HTIs are being monitored by the HR department in the MOH.

The public sector staffing levels versus the MOH staffing norms (latest version 1999) shows an enormous HRH shortage across all main cadres but is worst among nursing cadres and Clinical Officers / Assistant Medical Officers with fill rates as low as 30% (Kurowski et al, 2003). Moreover there is a huge difference between urban and rural deployment of HRH, as well as a disparity between regions in Tanzania.

Traditional professional divisions between cadres are being maintained in training, although the HRD policy of the MOH in 1995 advocated an integrated PHC approach in health, which requires more polyvalent cadres to provide essential services at grass-root level.

As part of the HSR and in particular the rationalisation of HR some cadres are being phased out e.g. RMAs, MCHAs, Nurse Assistants and Medical Attendants. The MOH is providing training programmes to upgrade these cadres. However, there seems to be insufficient capacity for the upgrading of all these cadres by the target year of 2007.

The National Centre for Distance Education has developed all the necessary modules for the upgrading of RMAs and MCHAs. Due to the premature termination of funding

and the Nursing Council's reluctance to recognise this upgrading of the MCHAs, this initiative has come to a slow-down. Thirty-eight (38) Clinical Officers have graduated but there are over 600 enrolled distance learners who could continue with their studies.

Recently, the need for 15,000 additional staff to address the needs of a new ARV programme was identified. How these cadres would fit into the regular health services, remains unclear, as well as the training programme for these new cadres. The programme may affect cadres already in place.

4 Situation Analysis of the training system

4.1 Functions of the training system

4.1.1 Training needs assessment

Individual and job related needs
There is no standardised approach to the identification of individual and job related training needs. Line managers assess training needs/performance gaps mainly through supervision and to a lesser extent through generally closed performance appraisal. Recently an open performance review and appraisal system (OPRAS) was introduced under the Public Service Reforms, but is not yet widely applied.

In practice, the majority of health workers who want to upgrade their skills as part of their career development must identify upgrading opportunities themselves and salary increments remain the main incentive for upgrading. There is anecdotal evidence that suggest that health workers, after returning from upgrading courses, often have to return to their old position because there are no positions within the health facility for the particular upgrading undertaken (e.g. ophthalmology, dermatology, health education).

In accordance with the devolution policy the districts and regions are responsible for conducting training needs assessment for pre- and in-service training, as well as local training for maintaining skills and knowledge. There are limited guidelines or practical tools available to the districts to support decentralised TNA processes for PST and CE. Under the RCH project, training needs assessment tools were developed and the assessment was conducted through CEDHA and PHCI and training programmes to meet identified gaps were delivered. Under the Health Sector Reforms the HSR secretariat is training CHMTs in performing training needs assessments and in contracting external institutions for performing CE training activities.

Currently the national (vertical) programmes continue to set the agenda for a large part of the informal (on the job) CE, which focuses on topics, which receive much donor attention like TB, AIDS and RCH. This results in the inequitable availability of training opportunities, with some cadres receiving frequent training and others not at all. Although the private sector (including the voluntary agencies in particular) plays an important role in the delivery of pre- and in-service training, it is not involved in the TNA process.

4.1.2 Information and communication

Information regarding training supply, opportunities, entry requirements and other procedures is not readily available at the periphery. De facto, the dissemination of information is not reaching those people and institutions at which it is targeted. A comprehensive brochure was developed by the MOH in 2002 but has not been disseminated adequately. School leavers and health workers mainly depend on irregular government circulars, HTI brochures and very limited electronic information to access training information and opportunities.

4.1.3 Selection of training entrants

The selection of entrants to pre- and in-service training courses has not been decentralised to the local government level. The MTs may in some cases be involved in the initial selection of candidates for in-service training, but the final selection of entrants for government training institutions is done by the central MOH, and by the private training institutions for their intakes. NGO and private HTIs have to adhere to the entry requirements set by the MOH/HR department. The entry requirements are partly based on the Public Service Scheme (PSS), which sometimes conflict with health sector interests. For example, some qualified health workers who have upgraded their qualifications in the course of their careers may have only have attained Standard VII but be trained, qualified and performing well. Further upgrading may be impeded by PSS regulations.

The MOH selection process is not perceived as transparent: it is felt that criteria are not standardised or well communicated. The selection outcome is only communicated to those who are accepted for their respective courses; those who are not selected do not receive feedback, due to logistical problems. Moreover, selection criteria are based on knowledge only, tested through an entry exam, and not on performance in practice. As a result the MOH centralised selection procedures are negatively impacting on the training system, which aims to address performance gaps and career development. The current selection system is not based on equity and maintains the skewed distribution of trainees and graduates.

Many of the MOH training institutions and much of the training capacity is under-utilised, which is a concern given the severe shortage of HRH. Many courses are not fully 'booked/occupied' and a number of those candidates selected do not take up places. Some have received entry permits for more than one institution.
One of the other reasons may be failing to raise the required amount for fees (cost sharing). All the pre- and in-service training schools require candidates to share the costs of the training. The share in the costs represents approximately 20% of the real costs for the MOH HTIs and range from 140,000 TShs. for certificate courses, to 160,000 to and 200,000 TShs respectively for diploma and advanced diploma courses. Non-citizens have to pay approximately sixteen times this amount. Cedha, PHC Iringa, KCMC and Muhimbili institutions charge the real training costs, which are higher than those cost-sharing fees.

The MOH has produced guidelines for CPD (MOH, 2003), but – in general – these guidelines for selection of participants in local CE training are not followed. The national programmes generally plan for their short courses without the full involvement of district level stakeholders and the CHMT has limited opportunities to select trainees according to local needs.

4.1.4 Curriculum development and revision

Pre- and In-service training
At present the MOH is responsible for the development of curricula for PST and In-service training, which is conducted in close consultation with tutors and specialists in the different areas. The national curricula are used by both government and private schools and can be locally adapted according to needs. The syllabi used for the actual training may therefore differ. The curricula for PST in health are still oriented towards traditional professional roles, taking little account of the new roles and functions under primary health care and health reforms. There is no training for district health managers, to mention one example. Improving the content of pre-service training could

reduce the present demand and need for intensive CE initiatives, is the feeling of some stakeholders.

Opportunities to build on recent developments and insights in e.g. epidemiology, health development, health sector reforms or training methodologies remain limited as long as the process is centrally controlled and revisions are only occurring once in 5 years.

Local short courses, workshops and other informal CE
Local courses for updating health workers skills and knowledge are based on national programme curricula developed at the national programme level. They are generally implemented through a ToT approach, with modules being developed by HTIs or the ZTCs, or (certified) trainers identified by the MTs developing training outlines which are delivered through on-the-job clinical meetings, mortality meetings, etc. There appears to be great variation in the quality of content and methodology. Co-ordination between the various providers of short courses at district and lower levels is generally poor and not actively sought.

Hospital and health facility based CE, in the form of e.g. clinical meetings or morning reports, are also approaches used in the delivery of local, informal CE. There is generally no curricula developed for these and they are not included in the district health plans, but they are indispensable in updating health workers on the job.

As part of the decentralisation the RAS/Council are expected to play a key role in the operational management of locally based CE/on the job training through planning and budgeting. This could be constrained by the fact that they have limited control over the content of the training given by vertical programmes. Opportunities for stakeholders at district level to participate in local course development are only very gradually being created.

4.1.5 Commissioning and delivering training

The MOH is the main provider of health care services and also the main provider of trained human resources for health. At the same time, the voluntary agencies play an important role both in the training (especially enrolled nurses) and supply of trained health cadres and in the consumption of this trained resource.

The MOH and voluntary agencies have established a total of 106 training schools[4] throughout the country, for pre- and in-service training of the 37 health cadres, with the majority owned by the MOH. The schools provide a wide range of training courses, awarding certificates, diplomas and advanced diplomas to graduates in nursing, medicine and other allied health sciences. Faith-based organisations run approximately 15 certificate or diploma (general, psychiatry, midwifery) Nursing schools and a number of CO and Laboratory Assistant schools.

The National Health Policy and HRD policy define the national priorities for HR knowledge and skills for the sector. This implies that the training supply offered by the HTI needs to reflect these national priorities.

Commissioning of on-the-job training is sometimes in the hands of MTs or health facilities and sometimes in the hands of national programmes. The latter type of top-down commissioning is not included in comprehensive council health plans and not budgeted.

[4] Information guide for courses offered by HTI in Tanzania. MOH December 2002

Under the HSR programme, CHMTs can now commission on-the-job training programmes, financed from the Danida Health Sector Support Programme.

4.1.6 Quality assurance and control of health training

Officially all training institutions except for the universities need to be registered and accredited by NACTE under the Ministry of Science and Technology, but in practice, few HTIs have been accredited, with the majority being registered only. To date NACTE has not been involved in assessing the curricula and capacities of health training institutions. While NACTE is developing its Quality Assurance systems e.g. "Policy and Procedures for Examination", the MOH is mandated to control and assure quality in its own institutions.

At the same time the Nursing and Midwives Council and Tanganyika Medical Training Board play a role in setting training standards, approving curricula and developing examination regulations. They appoint external examiners who ensure that there is no bias or favouritism and that uniform standards are exercised during the conduct of an examination.

As described in the paragraph on curriculum development, the respective roles in QA and QC are not clearly spelled out and are a source of misunderstanding at national, Zonal and district level. It is moreover unclear what quality control/assurance mechanisms are in place for the training for the vertical programmes. The MOH sees a role for the ZTCs in a decentralised system in the supervision and capacity building of health training institutions. However, currently the majority of the ZTCs have no formal relations with training institutions in its zone.

4.2 Institutional arrangements

4.2.1 Organisational structure

Most of the HTI are small and are concentrating on one type of cadre only. These institutions have a very narrow focus.
The Government training institutions are directly under the MOH; they do not have a Governing Board or Academic Board. In principle the HTIs reports to the unit of their speciality in the HRD directorate, like nursing, allied health or CE. Training institutions, which also have a ZTC function, therefore have double lines of authority if the HTI does not fall under the CE unit. According to training institutions, it is not clear how budgets are determined, or how priorities are set or how in general decisions are made in the HR department in the MOH. However, the MOH is of the opinion that budgets are based on the proposals submitted by the training institutions and that these budgets are transparent.
Health-related training institutions under MSTHE (presently only institutions directly under the University) have a clear organisational structure, with Boards and procedures.
The private institutions are independent and have their own structures, often a Governing Board, but rarely an Academic Board. These private institutions define their own priorities, formulate their own budgets, and decide themselves on the staffing.

4.2.2 Human Resources for training

In government HTIs the MOH employs all tutors and defines staffing levels for these institutions. CEDHA and Iringa PHCI have been accorded special staffing levels,

different from other HTIs. Part of the staff in Church-owned HTIs is seconded by the MOH. Transfers of staff and promotions are decided in the MOH-HQ.
Although the principals of the institutions are required to have a diploma in health personnel training (CEDHA diploma course), this is not recognised in the Scheme of Service or used to determine salary scales. Currently, there is no clear career path for tutors beyond their conventional clinical career path.

Trainers/facilitators for on-the-job training are sometime drawn from training institutions, and often from CHMTs, RHMTs or hospitals. Some national programmes provide a kind of ToT to "accredited" trainers. Some ZTCs maintain lists of accredited trainers in various subjects.

4.2.3 Infrastructure

The infrastructure in many HTIs is insufficient. Maintenance of buildings is overdue and often the space is not adequate for the standards defined by NACTE. Often, the infrastructure is not conducive for introducing innovative approaches in learning.
The equipment of most training institutions is inadequate; in most cases modern teaching aids, like computers and LCD projectors are lacking. Multi-media training materials are lacking even in the better equipped institutions.
Libraries are often inadequate, and do not offer the students access to internet.

4.3 Zonal Training Centres and training functions

Functions performed by the Zonal Training Centres:

1. Some ZTCs perform Training Needs Assessments in collaboration with regions, districts or health facilities. This is done in the context of projects, like the RCH project. It is not a part of regular functions of ZTCs.
2. Development of training content is done by institutions like Cedha or PHC-Iringa, more as part of their CE activities. Other ZTCs are involved in development of training programmes only on an ad-hoc basis, and have very limited capacity to undertake initiatives in that direction.
3. Provision of training is done under the name of the ZTCs, but in reality by the staff members of the training institution, where the ZTC is lodged. Some ZTCs wait passively for orders (as well training modules and funds) from the MOH, before they come into action. All ZTCs have been involved in the capacity building programme for CHMTs.
4. In certain areas the ZTCs contract external facilitators/resource persons to deliver training at district or facility level.
5. In some projects ZTCs have performed trainee follow up, workplace support and mentoring to ensure that class-room training is implemented in practice.
6. Evaluation of impact of training on the performance of health workers has been done in certain instances.
7. When resources are available, the ZTCs facilitate the dissemination of IEC, MoH guidelines and protocols and strengthen resource and information exchange in Zone
8. When funds were available the ZTC supervised Health Training Institutions (public, private, voluntary/church) in zone

The functions performed by ZTCs are in general seen as very useful for supporting and strengthening PST and CE, but are limited because of availability of funding. Cedha and PHC-Iringa have been able to develop their functions as ZTCs better than other ZTCs, probably because these two institutions are already geared towards CE; the other institutions in Mtwara, Mwanza, Kigoma and Morogoro are focussing on pre-service or in-service training. Cedha and PHC-Iringa are also better staffed and attract

more external funding than other institutions. Only with external donor funding, the functions listed above could be carried out. As a result, some of the ZTCs are more or less dormant, due to lack of funding.

Institutional arrangements of ZTCs

Presently ZTCs are directly under the MOH, under the Department of Human Resources Development. They have no autonomous legal status, but derive their status from being part of MOH-HQ. The ZTCs do not have a uniform organisational structure. In general ZTCs are attached to other training institutions and the principals perform double functions. Personnel in training institutions are directly employed under the MOH. In some cases, especially in times of resource constraints the regular training functions get preference over the functions of the ZTCs.

PHC-Iringa and Cedha have developed their own programmes, are generating part of their own income and have achieved a degree of independence from head quarters, mainly because of historical reasons. Cedha was funded by donors (AMREF) for training educators in health, while PHC-Iringa was tied to a regional PHC programme and provided training paid through programme funding. Other training centres have not developed their own programmes and are largely dependent on the MoH. The MOH-HR department provides some small funding for administration and transport to the training institutions for performing ZTC functions.
The ZTCs in principle have buildings, most of these provided under a World Bank programme in 1999. In many cases these ZTC buildings are also used by the HTI, where the ZTC is lodged.
Only Cedha and PHC-Iringa have a resources centre and have computer lab with sufficient access to internet. Other ZTCs have limited access to information, and sometimes not even computers with an internet connection.

4.4 Resource mobilisation, allocation and utilisation

Government policy

The Government has taken measures aimed at overhauling the public financial management system. Financial reforms are aimed at improving the efficient collection, allocation and utilisation of public resources. On the revenue side, the Tanzania Revenue Authority has been created, while on the expenditure side several budgeting, planning and accounting reforms have been instituted, these include Performance Budgeting, PER, MTEF, IFMIS. These will promote strategic resource allocations to priority areas through these new mechanisms, including technical training. The Government has also introduced block grant subventions to finance its obligations to local authorities. Sector specific common basket funding mechanisms have been established, which have specific allocation criteria.

Health Training Institutions

Recent consultancies on training found that financial and accounting data, at the national level, is sparse and of low quality. Public Expenditure Reviews do not provide for in-depth analysis of the different funding variables for training, such as by type of trainings i.e PST, in-Service and on-the-job, or by level of care, etc.

The total cost of training in health institutions is not fully known, though an exercise is currently being conducted to estimate a unit cost for each institution. All training institutions receive two main types of funding, Personal Emoluments (PE) and Other Charges (OC), regardless of the number of students, level of performance, application of qualifications by those trained, etc. The budget that comes with the subventions is defined in the MOH-HQ (based on draft budget provided by training institutions). The

provisions under the public financial act of 2001 make it impossible to use the funds according to locally defined priorities. Often the funding is insufficient, making it impossible for training institutions to provide the teaching according to defined standards. The HTI do not have a guaranteed minimum funding.
This method of funding does not encourage institutional efficiency or motivate HTIs to qualify students in the best possible time, and produce quality outputs. There is an imbalance between expenditure on salaries and overheads and expenditure on teaching materials and support. An expenditure analysis done in 2003 in training institutions in all sectors found that the relationship between personnel costs and other recurrent costs is not proportional, and within recurrent costs the amount that is actually allocated to teaching and learning materials is small and fluctuates.

The private institutions charge a full student fee, instead of the cost-sharing fee in government institutions (which is supposed to be 20% of the real costs). In reality, the church owned institutions have flexible payment conditions, enabling payment in instalments, even after completion of the training.

The return on investment in training is not being adequately measured. Efficiency has been based on delivering training programmes at the lowest costs, without an analysis of the outcome of the training versus the input costs.

There is little monitoring and evaluation of the efficiency and effectiveness of training at systems level. The Government plans to revise its funding methodology in order to ensure that the process better supports strategic priorities and encourages institutional initiatives, as well as the more effective use of resources. It is also planned to introduce both stimulation and equalisation principles in the funding mechanism.

4.5 Conclusions of the situation analysis of the training system

In all aspects of the training system (in planning, implementation, monitoring and evaluation) the role of the MOH-HQ is still very strong. Training has not been decentralised (either devolution or deconcentration) to the same extent as it has been for health service delivery under the health sector reforms.
It may be questioned whether the present practices of training needs assessment and admission to training (both PST and CE) are indeed serving the needs of the health services. Efficiency seems to be low.
The development of curricula and training programmes is equally centralised. Although this may be justified for economies of scale, it appears to lead to rigidity and lack of adaptation of training programmes to the quickly changing needs of the health services. The HRD policy of increased focus on PHC has never been implemented.
For the delivery of training programmes, the HTI face serious shortages of funds, equipment, infrastructure and human resources. Some institutions may not have the necessary size to survive a rationalisation programme as foreseen under the Sub-Master Plan for Higher Education.
Quality assurance is still in its infancy. Although NACTE has been empowered to initiate QA measures, it still has not the capacity to perform these tasks. Moreover, overlap between NACTE on the one hand and the Nurses and Midwives Council and Tanganyika Medical Training Board on the other hand, may not be conducive for improving the quality of training institutions. Presently supervision of training institutions is limited.

With regard to on-the-job training, the training needs assessment of health workers is minimal, though the new OPRAS may open new opportunities and though under certain projects experiences have been gained.

The planning and implementation of on-the-job training is still done in a fragmented way, where national programmes often operate in parallel and interfere with CHMT programmes. CHMTs and health facilities also provide on-the-job training, sometimes using accredited trainers, but sometimes operating completely independently. The quality may not always be sufficient and monitoring or follow up is limited.
In those instances where ZTCs have been involved in on-the-job training it has been satisfactory. However, most of the ZTC activities are limited to externally funded projects.

5 Plan for consolidating and strengthening PST+CE

5.1 Introduction

Section 3 above provided information on the policy context (the macro level) and section 4 on roles, relations and institutional arrangements (the micro level) in PST and CE, as well as the role and place of ZTCs in HRD in health.
It may be concluded from these two sections that there is a need to address the field of training in the health sector in a more comprehensive manner. Piecemeal solutions to improve functioning of the ZTCs will not result in major improvements in the training system. Bold steps are needed to bring the necessary improvement as soon as possible.

The proposal for improvement of PST and CE should lead to the following results:

- Bring the HTIs in line with the health sector reforms and the education sector reforms: introduce **decentralisation** through deconcentration or delegation where possible;
- Increase **efficiency** and **effectiveness** of the HTIs, by better utilisation of their capacities and infrastructure, and by directing them more toward the needs of the health sector;
- Enhance **quality** of PST and CE, so that training programmes can meet NACTE standards and improve health sector performance ;
- Increase the **cohesion** between PST, in-service training and on-the-job training: increase exchange and cross-fertilisation between training programmes and courses;
- Enhance **integration** of on-the-job training provided by national programmes into HRD activities in the Zone;
- Stimulate **innovation** in teaching and training, through new teaching methodologies (e.g. problem-oriented learning, distance learning, modular courses, ICT).
- Provide a **futuristic vision**, which will enable the training sector to face the health challenges of the 21st century.

The next two sectors describe the vision of Zonal Health Training Institutions (5.2) and the broader context of PST and CE (roles of other stakeholders) (5.3).

5.2 The Vision

This section describes the vision of PST and CE in the health sector in Tanzania as developed in close consultation with core stakeholders. This vision should be realised in the three year's programme period, which is described in chapter 7. The time needed to indeed realise this vision depends to a large extent on commitment and leadership of the MOH. In the view of the consultants with full commitment and with sufficient investments, much can be achieved.
Subsequent chapters will deal with the steps to achieve this, necessary adjustments to be made legislation, organisation, investments and intermediate solutions.

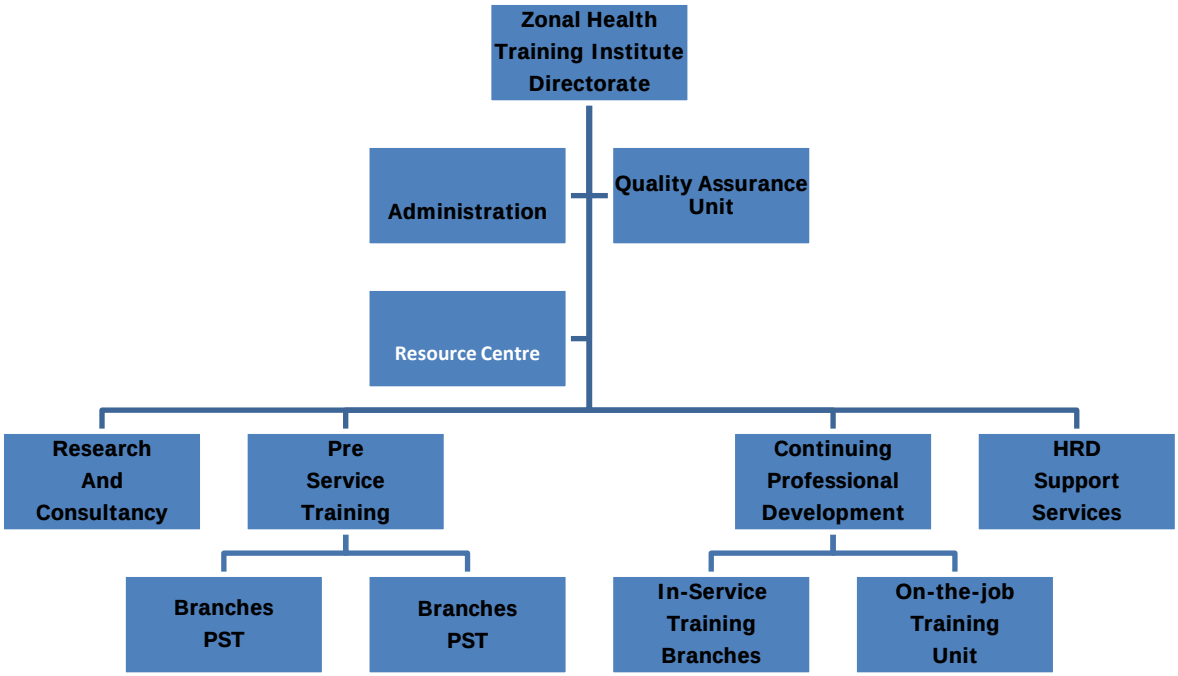
5.2.1 The set-up of Zonal Health Training Institutes

The number of Zones will be expanded from six to eight, by adding Central Zone in Dodoma and South-Western Zone in Mbeya. In these eight Zones Zonal Health

Training Institutes (ZHTIs) will be created, which bring together all PST and CE functions in the Zone.
All MOH-owned training institutions and the ZTC in a particular zone will be integrated into the ZHTI in that Zone (with some defined exceptions). The health training institutions will thus become branches of the ZHTI. Obviously, the ZHTI will operate in multiple locations.
Each ZHTI will be managed by a directorate, which is supported by an administration, a quality assurance unit and a resource centre.
The ZHTI will have four departments:

- Pre-service training: managing all PST programmes within the Zonal institution. Existing PST training institutions will be managed by this department.
- Continuing Professional Development, which covers the areas of in-service training and on-the-job training. Existing in-service training institutions will be managed by this department.
- HRD support services: assistance to clients (Management Teams from Council, Region or Hospital, as well as MOH and programmes)
- Research and consultancy: contracted by clients for specific services and research into HRD-related issues.

Figure 2: Organisational structure ZHTIs



5.2.2 Functions of ZHTIs

ZHTIs will have delegated MOH functions of information, coordination, and facilitation of training in the health sector and also have training implementation functions.

Information by ZTCs

The ZHTIs will have resource centres, which will provide information to the MTs, but also private health service providers and NGOs. These ZHTI resource centres will provide information on pre-service and in-training training programmes, on available

short courses and other types of on-the-job training. The resource centres will maintain a data base of trainers (generally certified by National programmes) and distribution of Health Learning Materials (HLMs) to trainers (within the ZHTI, in CHMTs, in health facilities, in NGOs, etc.). Networking with other ZHTIs will enable distribution of materials all over the country. The MOH will be part of the network and can disseminate necessary information on training activities and HLMs. For this network, all ZHTIs will have access to broadband-internet connections and modern ICT technology, which will allow them to communicate freely within their institution, and with other institutions.

Facilitation of training

ZHTIs will provide formal pre-service and in-service training through its branches; the quality assurance unit will provide assistance to training branches through supportive supervision, in developing training programmes and in developing internal quality assurance and monitoring mechanisms. The Zonal directorate is responsible for the full accreditation of the ZHTI and all its branches by NACTE.

The ZHTIs will enable on-the-job training. ZHTIs may be contracted by national programmes, organisations or MTs to provide this on-the-job training. Therefore different modalities can be applied:

- The ZHTIs can use staff from within the organisation (in the branches) or can contract-in trainers who implement training under direct responsibility of the ZHTI.
- The ZHTIs can also contract-out training to certified trainers or certified organisations in the area. The ZHTI remains responsible for the quality of the training.

Coordination

The ZHTI directorates provide opportunities for linkage and exchange between relevant stakeholders. First of all, the ZHTI coordinates between MTs and MOH-HQ:

- The ZHTIs coordinate with the MOH-HRD department the HR issues, e.g. curriculum development, implementation of training programmes, scholarships, CE activities. Because the number of institutions will be much smaller than now, the transaction costs for the MOH will reduce.
- The ZHTIs coordinate with the MOH departments of hospital services and preventive services (national programmes) CE for districts and hospitals.

Coordination among the ZHTIs is very important. Each ZHTI could specialise in certain areas and use the network to identify suitable advisors.
Presently, the task of bringing the health system up to speed with regard to HIV/AIDS, especially ARV treatment, is an area requiring attention. There are other areas like IMCI, district management, TEHIP tools, which could be scaled up using the ZHTIs. Also the hospital reforms process could be an area in which ZHTIs play a central role.

Support

The ZHTIs can assist MTs, and private providers to do Training Needs Assessments, by providing information and developing the capacity of the clients, rather than performing the TNAs.
ZHTIs can provide advice to clients in areas related to HRD, making career development plans, etc. The ZHTIs can assist in planning for CPD, in developing innovative approaches, etc.

Consultancy and research

ZHTIs could facilitate operational research into CPD activities and assist organisations in developing appropriate research protocols, etc.
ZHTIs could contribute to developing capacity in HMIS and HRIS as part of developing evidence-based interventions in health.

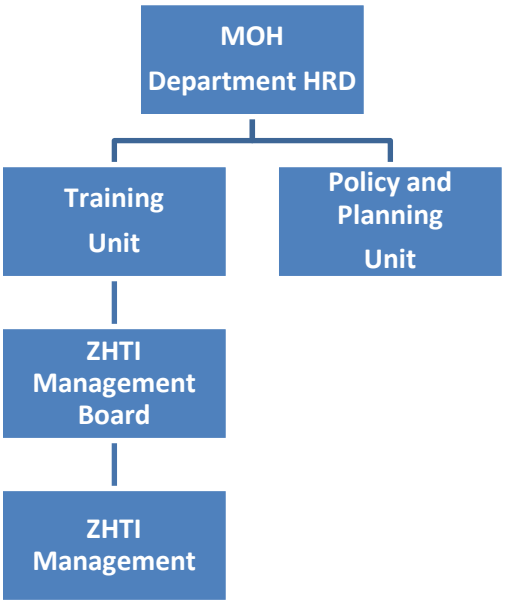
Management functions

The ZHTIs will perform management functions, like semi-autonomous institutions do, i.e. planning, budgeting, implementation, purchasing, accounting, monitoring and evaluation functions. With autonomous day-to-day operations, the ZHTIs will remove many of the functions performed at central level from the HRD department in head quarters. By bringing the different institutions in the Zone under the umbrella of the ZHTI an economy of scale can be achieved.

5.2.3 Relations to the MOH and organisations within the MOH

The ZHTIs will become semi-autonomous, managed by a Board, in the context of the decentralisation programme. However, they will remain institutions under the MOH, and not be moved to the local government, because of their national functions.
The MOH will appoint the Board members and will appoint the director of the ZHTI. Furthermore the MOH will continue to provide policy guidelines, funding and supervision (quality control), being the core functions of the line ministry. Most functions presently performed by the MOH will move to the decentralised institutions. Therefore, the Department of HRD can be rationalised.

Figure 3: MOH – ZHTI relations

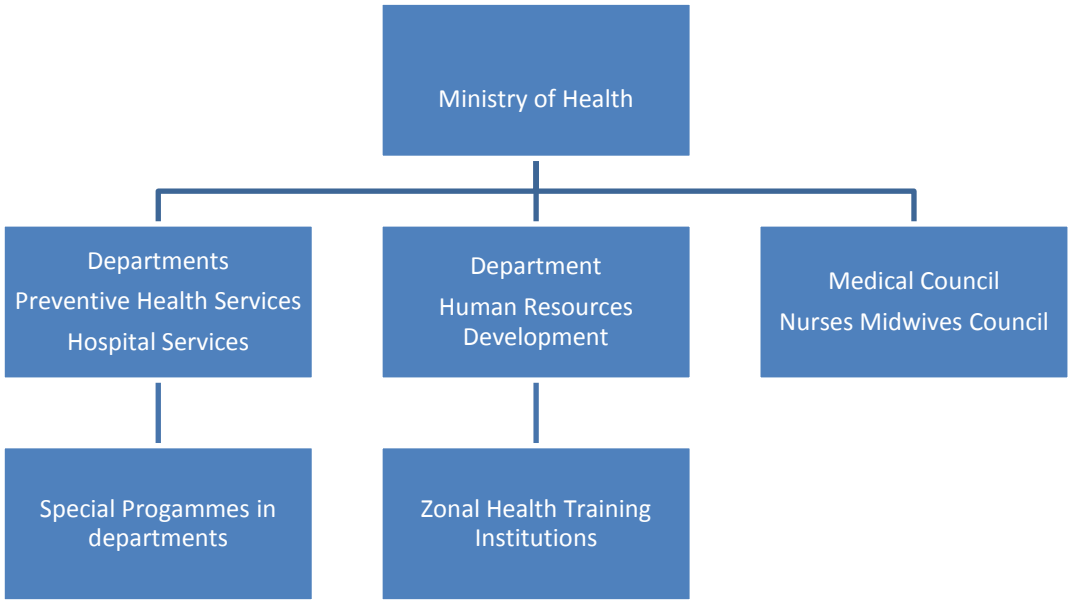


5.2.4 Relations to special programmes and councils

Presently, some of the special programmes tend to ignore ZTCs and HTIs and organise CE (or CPD) parallel to existing structure. The MOH has to convince those programmes to use existing structures. Within the MOH clear communication channels

have to be created through the HRD department, to enable contacts between ZHTIs and departments in the MOH. At the same time, training institutions must have the capacity to deliver quality CE as required by the programmes. The ZHTIs will indeed provide that quality, because of the capacity they develop in-house.
The Medical Council and the Nurses and Midwives Council will soon introduce obligatory re-registration of professionals, and will introduce gradually obligatory updating of knowledge through CPD as well. Professionals need to collect credit points for re-registration through CPD activities. ZHTIs should be the institutions which certify short courses and issues certificates of attendance to participants. This will change the approach to CE completely. Health workers will see CE as something they need in order to stay in the profession (and not something the do for their boss) and they will demand that CE is certified, giving them credits for re-registration. This will force special programmes to use the official CE structures, instead of parallel activities.

Figure 4: relations between ZHTIs, special programmes and regulatory bodies



5.2.5 Relations to other training institutions

Most of the Government owned health training institutions will be brought under the management of the ZHTIs. However, it may be decided to leave some out for strategic or pragmatic reasons, like the schools which are affiliated to KCMC. Some schools are private institutions (mostly church-owned). Those institutions will be responsible for their own registration and accreditation with NACTE.
The ZHTIs will maintain close contacts with the other training institutions (both governmental and non-governmental) in their Zone, for curriculum development, certification of short courses, etc.
The ZHTIs will also serve a communication channel between MOH and other training institutions which remain outside the ZHTI structure.
Some of the personnel in private institutions seconded by the MOH may become part of the ZHTI and be seconded from there. Maybe some small private training institutions, too small to survive on their own, may want to engage in a special affiliation with the nearby ZHTI.

5.2.6 Gains to be made by ZHTIs

The ZHTIs will be able to achieve the following gains, compared to the present situation:

- **Economy of scale**: the present schools with 2 – 6 tutors are not able to engage in quality assurance, innovation of teaching methodologies, etc. They are barely surviving. The bigger institution will have a QA unit, which concentrates on quality and innovation, benefiting all training programmes and courses in the institution. The bigger institution can much more easily meet the quality criteria as defined by NACTE and be registered as one institution, instead of 5 – 10 separate institutions.
- **Multi-purpose institutions**: in branches more than one training programme can be organised: infrastructure and equipment can be shared; tutors can teach in different programmes; teaching aids can be exchanged. The institutions will function as polytechnics, but in different locations.
- **Cross-fertilisation**: formal teaching programmes and CE activities can exchange better contents and methodologies, e.g. updating information from programmes goes also into PST, modular courses can be derived from formal programmes, etc.
- **Closer relations to MTs**: as the ZHTI is operating from various locations, in all regions in the zone, the branches function as liaison between the Zonal centre and the periphery. This will improve service delivery to the MTs.
- **Simplify communication** between centre and periphery. Instead of dealing with 104 institutions, the MOH only deals with 8 ZHTIs (and some institutions which will remain outside this set-up).
- **Reinforcing Regional Hospitals**: most ZHTIs are situated near Regional Hospitals, and linkages could be reinforced, especially through HR linkages. This could be an element of the hospital reforms programme.

5.3 Functional roles and responsibilities in PST and CE

5.3.1 Overview

In the two national consultative conferences and the four Zonal consultative conferences, major attention was paid to the roles and functions in the PST and CE system. Stakeholders gave their views on desired operational and institutional changes in view of emerging policy changes. This section to a large extent reflects the conclusions of the deliberations in the conferences and is presented for consideration by MOH and other stakeholders.

This section looks at the different functions, as explained in chapter 2 and discussed in the chapter 4 on analysis of the system. It provides more detail than the previous section on the vision for the future of the ZHTIs.

This section discusses proposed changes in roles and functions of stakeholders, based on the generic functions of the training system. The following matrix summarises roles and functions for different types of training. The text below in section 5.3 follows this matrix.

Table 1 generic functions in the training system

	Overarching	**PST**	**In-service (IST) (formal CE)**	**On-the job (informal CE)**
General	- Health Sector Needs Assessment			
Pre-implementation		- Information - Selection of students - Planning courses	- Training Needs Assessment - Information - Selection of students - Planning courses	- Training Needs Assessment - Information - Selection of participants - Planning training activities
Implementation	- Coordination of training activities - Funding mechanisms - Quality assurance	- Curriculum development - Provision of training	- Curriculum development - Provision of training	- Development of informal training - Implementating training activities
Post-implementation		- Examinations - Monitoring & evaluation of training outcomes	- Examinations - Monitoring & evaluation training of outcomes	- Post test - Monitoring & evaluation of training outcomes

Pre-service training and in-service training have much in common, in the sense that the training is formal, leading to a certificate, diploma or degree, provided by formal training institutions. Several of the suggestions below for strengthening and consolidation therefore are similar for PST and IST.

5.3.2 Health Sector Needs Assessment

The MOH-HR planning unit should develop an overall plan for all training in the health sector based on the needs. The health sector includes private for-profit and non-for-profit service providers. The planning has to change from supply-based training (filling up training institutions) to demand-based training (responding to needs).
A reliable HR information system is of utmost importance for relevant planning.

The MOH has the mandate to conduct overall strategic planning for human resources in health. This task is vested in the HR planning unit in the HR department. As has been discussed above allocative efficiency is very important in order to make the most efficient use of resources. Therefore sufficient information on needed and available HRH is necessary.

The following factors need to be taken into consideration in the assessment of needs:

- The health sector needs:

- The right skills mix of medical, nursing, technical and support staff for running health institutions (based on e.g. the essential health services package)
- The right level of training (e.g. attendant, assistant, technician).
- The right numbers of staff (based on work loads)
- Future demands based on medical and technical developments in health in Tanzania (e.g. introduction of ARV in Tanzania)

The Health Sector Establishment could inform consideration of skills mix and level of training. The availability of job descriptions (including qualifications and competencies required) could also provide useful information. Accreditation criteria for private health institutions could provide information on the type of staff to be deployed in those institutions, while the available physical infrastructure (health facilities) and work load analysis could inform numbers needed. In a well functioning HRIS computer-assisted simulation models could provide the necessary information on national training needs.

- For assessing the current and future availability of human resources information is needed on present staffing and attrition trends, which could be provided through a HRIS.
- For assessment of training output (inflow into the HR of the health services) the production capacity and actual output figures of training institutions should be available.
- Little is known about the ever-increasing role of the private sector in the health sector and appropriate systems should be developed to capture and analyse this type of information.

It is also within the mandate of the MOH to institute new cadres in the health system and to initiate appropriate training programmes accordingly. The issue of appropriate cadres for the delivery of primary health care was referred to in the 1995 HRD policy, but does not appear to have been resolved to date. This proposed restructuring of the PST and CE system could offer an opportunity to re-open the discussion on appropriate cadres and training programmes for PHC (the so-called multi-purpose worker).

5.3.3 Pre-implementation activities

5.3.3.1 Training Needs Assessment

Training Needs Assessment (TNA):

- For individual TNA the OPRAS and performance management systems will be the basis
- Job-related training needs are defined by the MTs, while MOH-HQ (national programmes) may give advice based on technical developments in health
- Organisational needs are identified by the health service delivery organisations within the limitations of the official establishment

Individual training needs assessment

It is obvious that individuals are the most knowledgeable persons to identify their own training needs. Under a programme of Continuing Professional Development, individuals are encouraged to pro-actively identify training needs and to develop their career paths.

Under the Local Government Reforms systems have been introduced which support the assessment of training needs. The MTs have taken up their responsibilities as employers. The personnel audit undertaken in 2002 was a one-off activity to assess training needs, but this should be undertaken on an ongoing basis. The recently introduced open performance appraisal system (OPRAS) has the potential to support the identification of training needs. The system mainly looks at formal upgrading needs (in-service training), but could take a broader approach. There should be more attention to TNA in the preparation of on-the-job training (updating knowledge and skills). The system will need additional refinement for assessment of knowledge and skills of individuals. Models developed and applied under the RCH programme could be developed further. Supervision protocols could also support the assessment of training needs of individual health workers. The ZHTI support departments could develop guidelines for TNA and a database could be maintained in the CHMTs. VA and private sector providers could also use similar TNA tools, like OPRAS, for their staff and the TNA process could become an obligatory element of the accreditation mechanism.

Job training needs assessment
MTs have a responsibility in identifying training needs for certain jobs, but can receive an input from National level. Standard job descriptions should be available for all jobs (and are partly in place already). National health programmes may plan for introduction of new packages of knowledge and skills, but should use the regular system for implementation. The ZHTI network will play a pivotal role in communication and information.

Organisational needs assessment
While the MOH determines the overall sectoral needs in the country and sets the priorities, the district health services (as well as regional and referral hospitals) have to identify the needs of the organisation. Although establishments may spell out the desired staffing, the MT has to set priorities and identify which type of cadre (with what type of specialisation) is most needed. Gaps can be filled through recruitment or through upgrading/updating of employed staff. In order to achieve this, HR management capacities in the MT will need to be strengthened and the Councils empowered to execute these tasks.

Information systems
The development of electronic databases, which include staff and skill audits, staff qualifications, job requirements, gaps and proposed training programmes are essential to enable the MTs effectively manage their human resources. Developments under the LGR could be used to support this process. The information should feed into national level macro planning for HRH. The communication process could be facilitated by the ZHTIs.

5.3.3.2 Information on training opportunities

Information on training opportunities will be decentralised. The ZHTIs will be pro-active in advertising opportunities for training (PST and CE). Better contacts between CHMTs and training institutions are needed. Electronic media could be used for disseminating information.

Pre-Service Training and In-Service Training
Better dissemination of information may assist in improving the utilisation of training capacity. The MOH has produced an information brochure, which could be disseminated country wide through ZHTIs to all secondary schools and health facilities. In the context of decentralisation the ZHTIs will develop a more proactive approach in marketing courses at several levels e.g. national, zonal, regional, district. Such information will be made available electronically through a web-site for PST/CPD. The practices of private training institutions in advertising and publicising training could inform public sector developments.

On-the-Job Training
Currently, MTs disseminate information on on-the-job training to their health workers. ZHTIs will assist the MTs by mapping the CE supply in the zone, through electronic information systems and other means.

5.3.3.3 Selection of training entrants, entry requirements, recruitment

Candidates for PST have to meet the Government requirements of Form IV for entry into training; however, for health workers who apply for in-service upgrading an exemption could be made.
Selection of candidates for PST and CE is done by the (future) employer. New financing mechanisms of training institutions (scholarships, bursarships) could facilitate the shift from centralised to decentralised selection.
ZHTIS will select students on capabilities or academic criteria. Central examinations are no longer required.
Selection of candidates for on-the-job training should be based on OPRAS criteria.

Pre-Service Training
One important entry requirement for training is the minimum entry requirement of Form IV for the Public Service. It would be logical to apply this entry requirement to all new cadres and exempt health-workers who graduated with a certificate and diploma before such entry requirements were formulated, even if they were to seek further upgrading now.

The decentralisation of selection of entrants is a contentious issue. Presently, private training institutions perform their own selection (utilising minimum entry requirements centrally formulated). There is no reason why the MOH-HQ should continue with the current practice of centralised selection and distribution of students over government PST institutions. One could argue that Councils or Regional Administrations should also be involved in the selection process. The funding mechanisms for training could be revised (see below), empowering the Councils to make a pre-selection (before the ZHTIs makes a final selection). Through bonding mechanisms the Councils could ensure that trained health workers indeed render for some period of time their services to the Council. This system already exists in NGO hospitals that send trainees to private training schools. Risks of nepotism or corruption entering into the system could be avoided by strict and transparent procedures. Thus, selection of trainees becomes a powerful tool in equitable distribution of newly trained health workers over the country. It goes without saying that a good information system is needed, to identify annually how many and which type of trainees is needed per Council. Access to training opportunities could become an incentive for Councils to provide HR information to the MOH.

In-Service Training
In the selection for In-Service Training the job needs and organisation needs should have the upper hand, certainly if Government funds are involved in funding for the training. The CHMTs in close collaboration with the Council Personnel Officers could select those health workers who have been assessed and identified as needing in-service training. The OPRAS could be an objective tool in the selection process; it incorporates the individual training needs. ZTCs could advise CHMTs on the selection procedures.
It is highly disputed, whether central entry examinations for certain training courses are fair. They could be replaced by entry interviews conducted at the training institutions (for which assessment criteria may be centrally set).
In in-service training bonding mechanisms may be applicable like in PST.

On-the-job Training
Updating knowledge and skills is very important for every health worker. Expected changes in re-registration of health professionals (obligatory CPD) necessitate the provision of on-the-job training to all health workers. Health workers will actively seek opportunities for CPD (which meet individual, job and organisational needs) in order to earn credits for re-registration.
By linking on-the-job training to the open performance appraisal process and to supervision protocols, training needs can be identified. A local database of, staff and skill audit maintained by the CHMT can serve as a basis for equitable access to CE. A good information system is needed for this approach in selection of health workers for on-the-job training.

5.3.4 Delivery of training

5.3.4.1 Planning Training Programmes

The MOH – HRD department plans for the overall capacity for PST and in-service training, leaving room to training institutions to take initiatives in developing training programmes.
Private institutions can be invited to develop training programmes within the national training programme and enter into service agreements.
Training programmes should fit within the Public Service Scheme and should meet accreditation standards.
CHMTs and health facilities plan for the on-the-job training programmes.

PST and in-service
The MOH defines the overall training needs based on national health priorities. As has been explained in paragraph 5.3.3 above, it is a difficult process of balancing demand and supply for training. The MOH has to have a general plan for the required capacity of training institutions and the different courses. However, with changing funding mechanisms, the MOH can leave some of the capacity planning to the ZHTIs, which is presently the case with private training schools. Allowing a free market of human resources in health, implies market mechanisms in training for HRH as well. The MOH has to collaborate with the MSTHE for training of professionals in institutions of higher education under that ministry. Private institutions can take a bigger share in training of professionals.
The HRD department of MOH has to coordinate with PO-PSD when initiating new training in health, to ensure that the new training programme fits in a government scheme of services.

On-the-job training
MTs plan for on-the-job training based on training needs in district or hospital. National health programmes' training should be integrated in Comprehensive Council Health Plan. This mechanism has to be rigorously adhered to, in order to end the present waste of resources. The ZHTIs can support the MTs on request in the planning process and can play a role as broker between National health programmes and CHMTs. The ZHTIs will also perform the certification.

5.3.4.2 Curriculum development

The role of MOH-HQ can shift from implementing curriculum development to guiding curriculum development: formulation of end-terms in collaboration with professional associations, registering professionals.
ZHTIs can develop and update the curricula, develop syllabi and their own specific approaches, using their QA unit.
The MOH have provided guidance for on-the-job training (guidelines of 2003). ZHTIs will develop short courses

PST and in-service training:
For new training programmes, which ZHTIs want to start up, these institutions will have to develop curricula. Existing curricula need to be revised from time to time. The role of the MOH can shift from implementing to guiding. The MOH could issue policy guidelines on curriculum development and delegate curriculum development to the ZHTIs.
The curricula of courses delivered in various training institutions (like nursing, clinical officer training) will be reviewed every three years jointly by the ZHTIs, to incorporate developments in health sector. The QA units of ZHTIs will assist with innovative approaches, e.g. ICT based learning and distance learning. Through intensive contacts between ZHTIs and vertical programmes, they are kept informed of medical/technical developments.
Syllabi and teaching methodology will be developed by ZHTIs. Each ZHTI will have its own approach towards teaching and training and create its own niches in the market of training.

On-the-job training
The MOH will give guidance to National programmes how they should relate to health workers in the country, using existing mechanisms of planning and developing CPD. National programmes will work with the ZHTIs to develop courses, as these institutes have the distinct capacity in house to that effect.

5.3.4.3 Delivering training

In delivering training, innovative approaches are needed, e.g. modular teaching, distance learning, web-based learning. Courses have to be accredited by NACTE.
With regard to on-the-job training, MTs should use courses, certified by ZHTIs.

PST and in-service training
Increasingly, the ZHTIs will innovate their teaching methodology, will introduce ICT based and distance learning, and will provide modular teaching programmes. The ZHTIs will ensure that all courses are accredited by NACTE.

On the job training
The CHMTs will coordinate all training, but will use certified trainers or training institutions for actual delivery of training. Gradually only courses certified by ZHTIs will be given, as the participants need the credit points for re-registration.

5.3.5 Post training delivery elements

NACTE and HEAC are responsible for the examination procedures, to be maintained by the ZHTIs.
The professional bodies, like the Nursing Council and Medical Council can define end-terms of training programmes, which will lead to registration of the trainees.
More follow-up and practical guidance after PST and CE is needed to assist health workers in actual implementation of what has been learned and to help them overcome constraints to the application of new skills and knowledge.
Operational research into impact of training (especially on-the job training) is necessary to achieve more practice-oriented training activities and to achieve a better fit between training and the requirements of the job.

5.3.5.1 Examinations

Pre-service and in-service training
In technical education NACTE is (by law) responsible for setting examinations and standards (content and procedures), but needs to do this in collaboration with the MOH and Nursing Council, etc. NACTE is responsible for assessment of quality of education and training, but Nursing Council has a role in examining nurses to decide who should practice.
In higher education HEAC is responsible and has to collaborate with the Medical Council which defines the standards for validating degrees and diplomas.
There should be a linkage between the validation of curricula and the approval of examinations to avoid a situation where courses and examinations are not approved by the professional body involved.
Qualifications and awards have to be accepted, recognised and rewarded under the Public Service Schemes, e.g. the Advanced Diploma in Health Education and Promotion and MPH programmes. The MOH has a role in this regard in its relations with the PSD.

On-the-job training
Normally, on-the-job training does not lead to an official examination. However, an exit test may become more and more common. There could be several reasons for that. For example, modules are part of a formal in-service training programme, or the course gives credit points for re-registration. Evaluation of the application of learning and post training performance should also provide relevant information on learner proficiency and the quality of the training.

5.3.5.2 Monitoring and evaluation of training outcomes

PST & CE

The MOH is introducing a QA framework, which will address quality issues of PST and CE. As part of the quality assurance there should be a feed-back loop between performance assessment of individuals after training and the training institutions (and obviously feedback to the trainees and line managers!). Systems will have to be developed and implemented to monitor the impact of training organised by CHMTs on health services. Follow-up mechanisms will have to be implemented to assist health workers to apply what they have learned in training activities. The CHMT also should have self evaluation tools for on-the-job training. The ZHTIS will be part of the feed-back loop. ZHTIS will do operational research into the effects of training on service delivery.

NACTE will have its role in the validation of training courses and should be included in the feed-back loop.

6 The programme: steps in the change process

The previous chapter described the vision and desired system, which should be in place in PST and CE. This programme discusses a mid-term programme of three years to realise that vision. It discusses the set-up and procedures of a suggested programme of change. (See also the logical framework in Annex 1.)
There are five main objectives, which include: policy harmonisation, a strategic framework, roles and responsibilities, institutional arrangements, and support systems.

6.1 Goal, Purpose and Objectives

The overall goal of the programme is to develop and maintain the capacity of HRH to deliver essential health services in Tanzania. The programme goal is to consolidate and strengthen a decentralised PST and CE system for the health sector. This should bring the training system in line with government reforms, with international developments in HRD in health, and should prepare the training system for the present and future health challenges in Tanzania.

In order to realise the vision presented in section 5.2, the following is needed:

- **Policy decision and steering committee** to champion the process
- **Stakeholders consultation**
- **Harmonisation of relevant policies and legislation**, with an update of the HRD policy
- **Strategic framework** for implementation
- **Allocation of functional roles and responsibilities** for the implementation of the ZHTI concept and its ramifications as described in section 5.2.
- **Institutional arrangements** for the ZHTIs and MOH
- **Monitoring and evaluation systems** that will improve system efficiency and effectiveness.

6.2 Activities in the change programme

This section describes the proposed activities that should be conducted in the coming three years in order to achieve the proposed objectives and support the implementation of the overall change process.

6.2.1 Policy decision and steering group

Chapter 5 provides a bold vision on the future of PST and CE in Tanzania. If the MOH indeed wants to move in this direction, it has to come swiftly into action. First of all, this proposal (or amended version) has to be accepted as the basis for further programming. If the MOH indeed wants to use the financial year 2005 – 2006 for implementation, some proposals and budgets need to be elaborated in March – April 2005.
It is suggested that a multi-disciplinary steering group is appointed under the leadership of a task-manager in the MOH.
It goes without saying that the MOH-HRD department will have an important role in the steering committee. Also other MOH departments should be invited, as well as the Councils. The MSTHE should take a responsibility to assist the MOH in this endeavour, given the higher education reforms process. Experts from ZTCs and HTIs should participate in the steering committee. Representatives of development partners could be welcomed as well.

It might be expected that the MOH gives this steering committee the necessary mandate to take the necessary actions in the implementation of the change programme.

6.2.2 Stakeholders consultation

The MOH should initiate a process of stakeholder consultations, immediately after the adoption of this proposal, in order to gain maximum support and create a momentum for change. Within the health sector, stakeholders at various levels have to be informed and where necessary involved, both in the government and in the private sector.
Other government entities outside the MOH, which have been identified as stakeholders, need to be brought on board, especially the PO-RARG and the MSTHE.
Last but not least, development partners have to be involved, as driving forces behind programmes and as partners in funding the reorganisation of the training sector in health.

6.2.3 Harmonisation of relevant legislation, regulations and policies

Firstly, an **inventory** of existing and evolving legislation, regulations and policies relevant to the training system at all levels should be created. (See annex 2.) It is essential that this not only observes the health sector but also the general context e.g. public service, local government and education. The following legislation, regulations and policies are relevant for the reorganisation:

- Revised Health Services Act and organisational review of the MOH-HQ.
- Local Government Reform Programme 2002 - 2008
- Public Service Act of 2002
- Tanzania Constitution (Article 145 and 146) principles of devolution to and autonomy of local government authorities

6.2.4 Strategic framework to support the implementation of the ZHTI concept

The development of a **strategic framework** for the implementation of the HRD Policy and specifically for PST and CE will require **close harmonisation with Health Sector Strategic Planning**, planning of the National (vertical) Health Programmes, planning of other ministries, especially MSTHE, and regulatory bodies. The MTEF framework can serve as a basis for co-ordination. To achieve the necessary harmonisation **consultative mechanisms** should be utilised, to synchronise strategic and operational plans.
The strategic framework should be closely linked to the **HR planning process**: numbers and types of staff needed in the country, and specifically required influx of newly trained staff into the health system. This will determine the capacity of ZHTIs and types of training programmes offered.

6.2.5 Functional roles and responsibilities

Roles and responsibilities of the key players will have to be refined in order to realise the defined vision of PST and CE. These have to be outlined in **job descriptions** for individuals and **terms of references** and/or **performance contracts** for entities or institutions. In developing these, capacity requirements and/or constraints can be identified, which could be addressed through a tailor-made **capacity building** programme.
(See also section 6.3 business plan for the ZHTIs.)

6.2.6 Institutional arrangements

In section 5.2 a rough outline of institutional arrangements for the ZHTIs has been presented. The following elements require further elaboration:

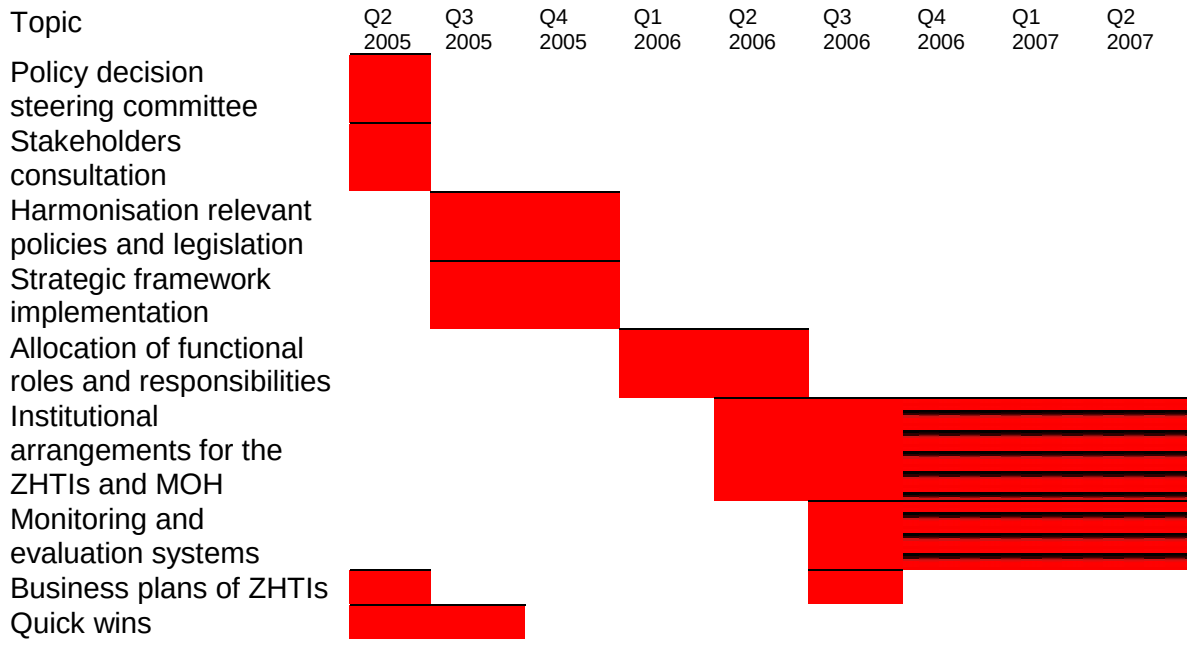
- **Structure**: organogram, status and mandate
- **Resources**: staffing, financing, infrastructure
- **Management systems**: planning, performance management, QA, M&E
- **Institutional linkages**/networking

(See also section 6.3 business plan of the ZHTIs.)

6.2.7 Monitoring efficiency and effectiveness of training systems

In PST and CE, issues of equity in terms of skills mix, geographical distribution, qualifications of cadres, etc. need to be considered and addressed. An **effective HRMIS**, which includes data from the private sector, could provide this type of information. Quality Assurance systems are essential for continuous quality improvement of the training system. The **assessment of the impact of training** (formal and informal) on the quality of health services is important for the overall steering of training activities.

6.3 Time frame for the programme



6.4 Business plans for the ZHTIs

The new ZHTIs will require comprehensive business plans. Initially, these business plans will have a transition character, while the MOH prepares policy changes, like decentralisation of tasks which are now with MOH head quarters. In a later stage, HR planning will determine the size of ZHTIs and types of training to be provided. The business plans should be made in the financial year 2005 – 2006, preferably before the end of 2005.

6.4.1 Assessment of exiting HTIs in the Zone

Before the business plan is made an **inventory** has to be undertaken for each Zone.

- Make an inventory of all training schools (public and private); assess the training programme; asses the human resources available in the schools; determine the capacity and the potential.
- Assess the available infrastructure (buildings, equipment, materials, means of transport, etc.)
- Assess the financial resources the training schools have. Probably most schools only receive government funding and student contributions.

6.4.2 Elements of the business plan

The **business plan** will look at several aspects:

Training programmes
Based on the existing schools, which will be incorporated in the ZHTI, and based on the needs in the Zone, the range of formal training programmes will be determined for pre-service and in-service training. Maybe some ZHTIs will develop specialities, e.g. distance learning programmes or new specialities of cadres needed in the country.
For on-the-job training all ZHTIs will develop the capacity to provide the wide range of short courses needed for updating all cadres in the health sector. Some may develop specialities for curriculum development, sharing the courses with others. Some may decide to contract in other institutions, instead of developing in-house capacity in all areas.

Other services
ZHTIs will develop resource centres, Quality Assurance Units, Department of Research and Consultancy, Department of HRD support to MTs. The ZHTI may decide to concentrate on certain areas, and make use of services of other ZHTIs for those areas that are less developed in their institute. Through intensive networking between ZHTIs this should be possible. The MOH-HQ also has a task to see to it that resources are effectively used.

Staffing
Staffing of training institutions is an important issue for improving the quality of training. First and foremost, it is important that teaching staff is included in the government scheme of services and that career development can be offered to health workers opting to work in training. The emphasis of staff development should be on multi-purpose training staff, able to teach different professional cadres.
In principle staff will be employed directly by the training institution. (This is one of the reasons why training institutions should have some critical mass.) Co-opted staff from e.g. hospitals can be used for certain components of the training programme.
The inventory of the existing HTIs will be used to redistribute staff, determine training needs, and – if need be – the necessary hiring of new staff.

Infrastructure
It is envisaged that most schools will continue to operate where they are located (as branches of new ZHTIs). However, some small and inefficient schools could better be closed and merged with other schools. The development of regional hospitals and their training functions could lead to relocation of some schools (branches of ZHTIs). Reorganisation of the schools may require new investments in infrastructure. Most of the schools need maintenance and repairs. Also equipment needs to be replaced or added. It is also recommended that all schools should get assistance to build up a

library, including multi-media teaching aids. All training institutions should have access to internet, preferably through broadband connections. ICT should not be considered anymore as a luxury, but as a basic commodity in the 21st century.

Financial resources

Under autonomy, training institutions should operate as business entities. This implies that direct payment of staff and some other costs by the MOH HR Dept. will come to an end.

Sources of income for schools will be:

- Government subsidies (warrant grants)
- Fees from students
- Contracts with clients
- Projects, income generating activities, etc.

The business plan will provide a budget and investment plan for the ZHTI.

Management systems

Systems necessary for academic activities will be based on the requirements of NACTE and HEAC and can – with modifications – be taken from autonomous training institutions under MSTHE.

Within the management system, there should be attention to internal quality procedures. Equally important is the development of a monitoring and evaluation system, which will provide information to the MOH on the utilisation of the capacity, outputs, availability of courses, etc. as an input for national level planning. A capacity building programme should be developed to provide the managers with the skills for autonomous management. Financial management systems may need to be put in place.

It is recommended that autonomous institutions should develop strategic plans and rolling plans within the MTEF framework, as is the current practice in CHMTs. The institutions should plan for the regular training programmes, short courses, CE or projects they could undertake.

Transition period

The business plan should incorporate a plan for the transition period. How can the tasks be gradually taken up and how can the organisational structure gradually be put in place? The transition period will also depend on the evolving policy and strategic framework.

After the transition period a revised business plan will come into operation.

7 Quick Wins

Quick wins in ZTCs
The ZTCs can improve their performance by some interventions, which can be made independently of institutional re-arrangements. The following quick wins are suggested:

- Internet (broadband) facilities could be brought to all ZTCs.
- Resource centres could be created, or expanded.
- Contracts can be made between ZTCs and programmes in the provision of a series of short courses, in IMCI, district health management, etc.
- Supervision of HTIs could be resumed, improving the relations and networking.
- Follow-up visits to trainees after completion of their training could be resumed, as has been done in the past in the context of certain training programmes.
- Within the ZTCs an information and registration system can be built up, providing information on training activities, training programmes, certified trainers, trained health workers, etc.
- ZTCs can take up a pro-active role in the distribution and implementation of distance learning courses, which have been designed in recent years.

Most of these activities can be performed with available human resources in the HTIs, but require some extra inputs in terms of financial resources and equipment.

The quick wins proposed in this chapter are those activities which might be implemented on the short term; do not require any policy change, and relative small investments.
The aim of these quick wins is to prepare the ground for the more comprehensive reorganisation process and to increase the visibility of the ZTCs. Where they are seen to deliver, it is easier to bring stakeholders on board in the change process.

- Internet (broadband) facilities could be brought to all ZTCs and MOH-HRD, enabling them to build up a national network of ZTCs and to get in touch with global developments in the field of HRD in health.
- Resource centres could be created, with access to Health Learning Materials for CHMTs and HTIs. Available materials from e.g. AMREF, Health Link, etc. could be made available through these resource centres.
- Contracts can be made between programmes and ZTCs to provide CME. Examples of courses are the IMCI programme, the modular course on district health management, the distribution of TEHIP tools. In these programmes all ZTCs should be involved and not only the “big two” of Cedha and PHCI.
- The distance learning programme for clinical officers and public health nurse-B[5] could be intensified, using the infrastructure and capacities of all ZTCs.
- Supervision of HTIs could be resumed, after discontinuation for some years due to lack of funds. The supervision could concentrate on building up the necessary relations for the comprehensive reorganisation process.
- Follow-up visits to trainees after completion of their training could be resumed, as has been done in the past in the context of certain training programmes. This will enable better implementation of knowledge and skills learned during training, and will provide feed-back to the training institution.

[5] The distance learning programme for PH-B needs adjustment, now it has been decided to have just one general nurse B diploma. The Nursing Council has to brought on board for this activity.

- Within the ZTCs an information system can be built up, providing information on training activities, training programmes, certified trainers, trained health workers, etc. This will not be a new information system, but will focus on pulling together and collating all the different strands of information available in districts, regions and programmes. This will support preparations for the future registration and certification of short training courses.

A tentative budget for the quick wins is provided in chapter 10.

8 Overall assumptions for the change process

8.1 Programme Goal

The programme goal is to consolidate and strengthen a decentralised PST and CE system for the health sector in Tanzania

Assumptions
- Capacity for managing change processes and outcomes exists
- MOH assumes new role and responsibilities for PST and CE
- MOH supports the decentralisation of all PST and CE implementation
- MOH Strategic Plan for Integration of Health Services is fully adopted, resourced and implemented
- Development Partners support a decentralised PST and CE system

The MOH should take responsibility for managing and leading the proposed change process. The MOH has a responsibility to ensure that the capacity of the local levels to undertake the delegated and devolved PST and CE functions is developed and adequately supported. HRD planning and implementation should be mainstreamed in plans to operationalise the Strategic Plan for the Integration of Health Services. The Development Partners should ensure that support and funding enhances integrated and decentralised approaches; that the HRD needs of the health sector, including the national programmes, are integrated into district planning processes; and a more long term focus is adopted for HRD and health systems change

8.2 Programme Objectives

Harmonisation of legislation and policies:
To harmonise HRH relevant policies and legislation to develop a comprehensive and integrated HRD policy

Assumptions
- MOH has capacity for participatory policy analysis, formulation, planning and coordination
- Inter-sectoral capacity exists for analysis of policy and legislation
- Inter-sectoral stakeholders are able and willing to collaborate
- MOH is building/has built adequate capacity for policy development and review
- HRD for health remains a priority for all stakeholders

Policy harmonisation and development should focus on both content and process. The MOH should proactively lead and manage inter-sectoral policy dialogue, analysis, coordination and development processes to ensure that evolving HRD policy is both informed by and informs policy and legislation development. The MOH should ensure that HRD remains high on the policy and health agenda; that it is perceived by others to be a priority issue; and that HRD strategies and systems improvements are perceived to be contributing to the achievement of health goals and outcomes.

Strategic framework
To develop a strategic framework for operationalisation of the ZHTI concept.

Assumptions
- Intra-sectoral capacity exists to contribute to a strategic framework for HRD
- HRH plan updated and HRD policy updated

- All plans will be costed and will have clearly identified targets and outputs

The MOH should promote and adopt participatory and consultative approaches in the development of strategic frameworks. All relevant external stakeholders as well as the relevant departments/units within the MOH should be involved. The MOH should ensure that the components of the strategic framework and operational guidelines are disseminated to the lower levels and monitored for adherence. Orientation/capacity development initiatives should be planned and implemented as necessary in order to achieve the expected HRD goals and outcomes.

Roles and responsibilities
To define and allocate functional roles and responsibilities for the implementation of the HRD Policy

Assumptions
- MOH and other stakeholders willing to allocate and accept new roles and responsibilities
- MOH and Development Partners will secure sufficient funding to resource new capacity needs
- Capacity exists to undertake new roles and functions

The MOH should lead and manage the negotiation and allocation of new roles and responsibilities. It is essential that these are agreed and formalised through agreed performance/service contracts and job descriptions. New appointments should be made through systematic and transparent recruitment and selection procedures and performance management systems applied to assess and review performance and identify performance gaps. The MOH should also ensure that new positions are recognised by the Public Service Scheme. A capacity development and change plan should be formulated and resourced if required. The MOH should take responsibility to ensure that information on the new roles and responsibilities are communicated to all relevant parties, including development partners, sector representatives, MOH departments and units, regulatory bodies, councils, and regional and district health management teams.

Institutional arrangements
To define and establish institutional arrangements for the implementation of the HRD Policy

Assumptions
- Sufficient resources will be made available to establish new institutional and organisational arrangements for HRD
- New institutional arrangements given appropriate status in recognition of their new mandate
- MOH and Development Partners will support capacity building of ZHTIs
- MOH, Development Partners and other relevant stakeholders will support new institutional arrangements

The MOH should lead and manage the negotiation and establishment of new institutional and organisational roles and responsibilities. It is essential that these are agreed, formalised and appraised through agreed performance/service contracts. The new arrangements should be recognised within MOH structures and other health legislation. A capacity development and change plan may need to be formulated and resources mobilised to support the effective operationalisation and functioning of the new arrangements. The MOH should be responsible for ensuring that information on

the new institutional and organisational arrangements are communicated to all relevant parties, including development partners, sector representatives, MOH departments and units, regulatory bodies, councils and regional and district health management teams.

Monitoring and Evaluation
To monitor the efficiency and effectiveness of the HRD system

Assumptions
- All relevant information systems are robust and provide accurate data for M&E and planning purposes, i.e. HRMIS, TIMS, HMIS, IFMIS, QA
- Information systems are in place: HRMIS, TIMS, IFMIS (Integrated Financial Management Information System) and HMIS.
- QA and QC systems developed and applied for HRD and informing HRD planning
- Systems in place to inform HRD planning process of new developments in technology and delivery approaches.
- Monitoring and Evaluation systems developed and applied and informing planning
- MOH have sufficient resources available to engage with regional and international health initiatives
- Capacity is built in the MOH to effectively utilise research findings and examples of best practice to strengthen health services delivery

MOH should ensure that the feedback loop between research, policy, programmes and evaluation is strengthened to inform HRD policies and policy decisions at the national level. Policy dialogue, analysis, coordination and development are continuous processes and the MOH must ensure that the process is informed by changes in national demography and health conditions, and regional and international developments, trends and best practices. While the current HRD systems may require some updating and adjustment, it is important to ensure that this does not result in duplication and/or overlap with current monitoring and evaluation systems. The MOH should ensure that the necessary linkages are in place to optimally utilise the data generated by these systems for strengthening the HRD system. Improved HRD monitoring and evaluation systems and procedures will ensure that information on HRD outcomes informs other elements of the system, such as training needs assessment, curriculum development and instructional design and delivery. Evaluation systems should also be utilised at the level of the learner to ensure that support and feedback promotes health worker motivation, satisfaction and commitment, leading to improved health sector performance and health outcomes.

9 Monitoring and evaluation

Monitoring and evaluating starts with the setting of goals, objectives and targets, and then agreeing suitable indicators to measure the progress towards achieving them. For the purpose of this proposal Objectively Verifiable Indicators (OVIs), and Means of Verification (MOV) have been suggested. The collection of indicators to measure progress requires a number of routine and non-routine data collection systems, the following are some of the systems used in and outside of the health sector in Tanzania currently that could be used for the purposes of this proposal:

Routine systems

- Human Resource Management Information System
- Training Information Management System
- Health Management Information System
- Integrated Disease Surveillance
- HIV/AIDS Sentinel Survey
- Annual Report of the MOH
- Three-year rolling strategic plan
- Disease programmes own information systems

Non-routine systems

- National Health Accounts
- Public Expenditure Review
- Integrated Household Living Conditions Survey
- National Population Census
- Research and surveys
- Reports and Minutes of Committee Meetings

Routine and non-routine sources of information, both within and outside the health sector, provide an abundance of data related to health worker training in terms of financing, training opportunities and demand. Yet, to collect and use data in an adequate manner, and to assess the overall performance of the provision of human resources for the health sector, by linking input- process- output- and outcome data provided by the various management systems and research, remains a formidable challenges and capacities will need to be built to do this.

Main responsibility for monitoring and evaluation of HRD for health will need to remain within the Directorate of Human Resources (DHR) in the MOH, with some responsibilities for data collection and dissemination to be delegated to ZTCs, RHMT/CHMTs. The DHR will need to ensure that HRD developments are both informed by and inform relevant M&E systems.

Non-routine systems such as research and surveys have largely been based on project and development partners' priorities or on academic imperatives; there is now a real opportunity for the MOH and the ZTCs to set a real agenda for HRD research to monitor issues relating to the implementation of national HRD policy for health.
There is a need to consider different fora for the dissemination of routine and non-routine data collections findings on HRD. This needs to be considered in the context of the overall management and planning cycle of the sector, and the role of monitoring and evaluation in the sector. There is a need to advocate for inclusion of HRD reviews in the regular annual consultative meetings on the sector as HRD is fundamental to sectoral performance. Greater use could be made of the new governance structures being proposed under decentralisation to disseminate and contribute to the overall monitoring and evaluation of progress on HRD for the health sector.

10 Resource Mobilisation and Budget

10.1 Resource Mobilisation

As already discussed in chapter 3 the Government has taken measures to overhaul the public financial management systems to improve the collection, allocation and utilisation of public resources more efficiently. Part of the Government's decentralisation reform is to devolve funding for training, including PST, to local authorities. This would need to be done as part of an overall strategy of funding of citizens for accessing higher, tertiary and technical education rather than be seen as specific sector funding to train and retain staffing for that sector. As part of this strategy study loans, bursaries or scholarships could be introduced by government.

With regard to formal training, it is recommended to change from the system of cost-sharing in training institutions to a full cost-covering fee structure, whereby the Government (MOH) can fund scholarships or study loans, etc. based on academic and socio-economic criteria. This will remove subsidies to persons who are capable of paying a full fee and will enable scholarships from Councils, the private sector, NGOs or collaborating partners. This financing system already exists in the private training schools in the health sector and is therefore not new in the system. It is recommended that the MOH become a funder of scholarships rather than a direct provider. The MOH can allocate a certain number of scholarships for pre-service and in-service training to District Councils and hospitals, based on criteria like staffing needs, equity of distribution etc. The Councils can select candidates, who go through a selection procedure in the training schools.

With regard to on-the-job training, MTs have funds available in their budgets. The basket funding provides a percentage for HRD activities. The comprehensive action plans, therefore, should have a budget for on-the-job training. With these funds the MTs can buy training from ZHTIs. Another source of funding can come from the national programmes, which in turn have strong backing from multilateral and bilateral donors. The Global Fund for HIV/AIDS, Malaria and TB for example provides funds for training. Bilateral donors, like USAID also invest considerable amounts in on-the-job training programmes, like IMCI and RCH.
It will require the MOH strong leadership, to turn the system from parallel financing to financing through the regular training system. However, when quality can be offered, it might be expected that the development partners can be more easily convinced than right now.

Funding the reorganisation will require multiple sources of funding. Probably, the rationalisation process of training institutions will result in savings compared the present system, with more efficient use of human resources and infrastructure.

At the same time investments are needed in infrastructure, in capacity building and new recruitments of staff. For the change programme, sources of funding have to be identified by the MOH.

10.2 PST and CE Proposal Summary Budget

Budget for Proposal for consolidating and strengthening a decentralised PST and CE system in Tanzania ***(USD$1:Tsh1,100)***

Activity No.	Description/Inputs	Unit Cost USD$	Total USD$ Year 1	Total USD$ Year 2	Total USD$ Year 3	Total for Activity
Programme objective 1: policy decision and steering group			**500.00**			**$ 500.00**
Programme objective 2: Stakeholders consultations			**12,000.00**			**$ 12,000.00**
Programme Objective 3: To Harmonise relevant policies and legislation			**53,700.00**		**6,700.00**	**$ 60,400.00**
Programme Objective 4: To develop a strategic framework to support the implementation of the HRD Policy			**37,000.00**	**2,000.00**	**2,000.00**	**$ 41,000.00**
Programme Objective 5: To define and allocate functional roles and responsibilities			**-**	**80,000.00**	**44,100.00**	**$ 124,100.00**
Programme Objective 6: To define and establish institutional arrangements for the implementation of the HRD Policy				**38,000.00**	**3,000.00**	**$ 41,000.00**
Programme Objective 7: To monitor the efficiency and effectiveness of the HRD system			**2,500.00**	**2,625.00**	**2,760.00**	**$ 7,885.00**
Total Budget for the Change Programme			**$ 105,700.00**	**$ 122,625.00**	**$58,560.00**	**$286,885.00**

Budget for Business Plan and Quick Wins for consolidating and strengthening a decentralised PST and CE system in Tanzania ***(USD$1:Tsh1,100)***

Activity No.	Description/Inputs	Unit Cost USD$	Total USD$ Year 1	Total USD$ Year 2	Total USD$ Year 3	Total for Activity
1	Business Plans for Zonal Health Training Institutions					$ 324,000.00
2	Rehabilitation and expansion existing 6 ZHTIs (including offices ZHTI directorate					$ 1,790,000.00
3	Establishing new ZHTI in Mbeya and Dodoma					$ 2,000,000.00
4	Annual Recurrent Cost of ZHTIs (transition period of transforming ZTCs in ZHTIs)					$ 3,827,714.00
5	Transformation of exiting health training institutions into branches of ZHTIs					$ 2,900,000.00
	Total budget for business plans and quick wins		4,794,800.00	4,093,280.00	1,753,634.00	$ 10,841,714.00

Annex: LOGICAL FRAMEWORK

FOR CONSOLIDATING AND STRENGTHENING PST AND CE IN TANZANIA

Goals/Objectives	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
Overall Goal To develop and maintain the capacity of Human Resources for health to deliver essential health services in Tanzania	All training opportunities provided for PST and In-service are availed of. Increased number of health facilities staffed by health workers adequately trained to deliver the national health package	Level of enrolment in all courses in HTI s No of health facilities adequately staffed to deliver the national health package, by level.	
Programme Goal To consolidate and strengthen a decentralised PST and CE system for the health sector in Tanzania	MOH guide and coordinate a decentralised PST system CE for all district health workers is planned for and funded through the CCHP	Guidelines for implementation of PST disseminated and applied CHMT annual reports	MOH assumes new role and responsibilities for PST and CE Training system is demand driven by autonomous hospitals and district councils MOH Strategic Plan for Integration of health services is fully adopted and implemented All Development Partners support a demand-driven decentralised PST and CE system

Goals/Objectives	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
Programme Objectives			
1. To adopt Vision for PST and CE and initiate steering group	Official adoption of proposal for PST and CE by MOH	Minutes Management Meeting MOH	Necessary momentum for change present
2. To consult stakeholders in the change process	Commitment by MSTHE, PO-RALG, development partners to the change process	Minutes of meetings, MOU, etc.	Mutual confidence in the change process
3. To harmonise HRH relevant policies and legislation to develop a comprehensive integrated HRD policy	HRD Policy developed	HRD policy being used to guide developments in PST and CE	Political will for harmonisation in MOH Inter-sectoral capacity exists for analysis of policy and legislation.
4. To develop a strategic framework for operationalisation of the HRD Policy	Strategy, operational plans and guidelines for HRD developed	HRD Strategy, operational plans and guidelines disseminated and in use.	Inter-sectoral stakeholders are able and willing to collaborate
5. To define and allocate functional roles and responsibilities for the implementation of the HRD Policy	New roles and responsibilities allocated to relevant stakeholders in support of new HRD policy	Analysis of annual plans and sector reviews demonstrate allocation and fulfilment of new roles and responsibilities Job descriptions of post-holders reflect new roles and responsibilities	Intra-sectoral capacity exists to contribute to a strategic framework for HRD Capacity exists to undertake new roles and functions. Capacity for managing change processes and outcomes exists
6. To define and establish institutional arrangements	Organisational and Institutional structures revised to support	Revised Organisational structure for MOH, ZHTIs	Sufficient resources will be made available to establish new

Goals/Objectives	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
for the implementation of the HRD Policy	implementation of HRD Policy	Sector reviews indicate improvement in the decentralised coordination of PST and CE	institutional and organisational arrangements for HRD
7. To monitor the efficiency and effectiveness of the HRD system	Availability and distribution of appropriately trained Health Workers improves.	Monitoring of HRMIS and TIMS	All relevant information systems are robust and provide accurate data for M&E and planning purposes, i.e. HRMIS, TIMS, HMIS, IFMIS, QA

Activities	Responsibility	Risks and Assumptions
Programme Objective 1: Adoption of vision and establishment of steering committee		
Propose officially to management of MOH the proposal, necessary amendments	Director HRD MOH	Sufficient support in MOH for comprehensive reorganisation of training sector in health
Establish multi-disciplinary steering committee with membership from MOH, MSTHE, ZTCs, DPs	Director HRD MOH	Willingness of other stakeholders to collaborate in the change process
Programme Objective 2: Consultation of stakeholders		
Inform and involve wide group of stakeholders at all levels with regard to the envisaged change process	Steering committee	Willingness of other stakeholders to collaborate in the change process
Programme Objective 3: To harmonise relevant policies and legislation		

Activities	Responsibility	Risks and Assumptions
Prepare an inventory of (internal and external[6]) existing and evolving policies, laws/legislation and regulations relevant to HRH Conduct analysis and identify inconsistencies Utilise analysis to prepare a HRD policy through participatory processes that is informed by existing and evolving policies, laws/legislation and regulations Disseminate updated HRD policy to relevant stakeholders	MOH with support from GoT Legal Advisers, Public Service Management, PORALG, MOSTHE and Professional Bodies. MOH (including ZTC) with support from GoT Legal Advisers, Public Service Management, PORALG, MOSTHE and Professional Bodies. MOH, ZTC, RHMT and CHMT representatives with support from Public Service Management, Professional Bodies and private sector representatives. MOH	MOH is building/has built adequate capacity for policy development and review Willingness of other stakeholders to collaborate HRD for health remains a priority for all stakeholders
Programme Objective 4: To develop a strategic framework[7] to support the implementation of the HRD policy Develop components of the strategic framework (strategy, business plans, guidelines, etc.) Facilitate the dissemination of	MOH and identified stakeholders MOH, ZHTIs, RHMTs and CHMTs	HRH plan updated and HRD policy updated All plans will be costed and will have clearly identified targets and outputs

[6] Within and beyond the health sector

[7] The strategic framework includes the plan, consultation process, resources mobilisation and strategies

Activities	Responsibility	Risks and Assumptions
components of the strategic framework Monitor the application and implementation of the strategic framework components	 MOH, ZHTIs and RHMTs	MOH has capacity for participatory policy formulation, planning and coordination
Programme Objective 5: To define and allocate functional roles and responsibilities Review and adopt proposed roles and responsibilities (guidelines, operational plans, job descriptions, performance and service contracts, etc) Define (individual and institutional) capacity requirements to fulfil new roles and responsibilities Develop plan and timeframe to address capacity building requirements for new roles and responsibilities Implement capacity building plan to fulfil new roles and responsibilities	 MOH, ZHTIs, MTs MOH in collaboration with ZHTIs, MTs MOH in collaboration with ZHTIs, MTs MOH, ZHTIs, MTs	 MOH and other stakeholders willing to allocate and accept new roles and responsibilities MOH and Development Partners will secure sufficient funding to resource new capacity needs
Programme Objective 6: To define and establish institutional arrangements for the implementation of the HRD policy Review and adopt proposed institutional arrangements	 MOH in collaboration with ZHTIs and MTs	 New institutional arrangements given appropriate

Activities	**Responsibility**	**Risks and Assumptions**

Prepare, adopt and disseminate guidelines for the management of PST and CE system to include:
- Structure: organogram, status and mandate
- Resources:
  - Staffing
  - Financing
  - Infrastructure
- Management systems: governance structures, performance management, M&E
- Institutional Linkages/ networking
	MOH in collaboration with ZHTIs	status in recognition of their new mandate
		
		MOH and Development Partners will support capacity building of ZHTIs
		
		MOH, Development Partners and other relevant stakeholders will support new institutional arrangements

Identify and plan to address capacity building requirements, agree a timeframe for implementation	MOH and ZHTIs	
Implement and monitor the establishment of institutional arrangements.	MOH and ZHTIs	
Programme Objective 7: To monitor the efficiency and effectiveness of the HRD system		
Monitor 'allocative efficiency' of PST/CE (equity in terms of level, geographical, cadre, PST/CE)	MOH with support from ZHTIs	Information systems are in place: HRMIS, TIMS, IFMIS (Integrated Financial Management Information System) and HMIS.
Quality Assure the inputs, process and		QA and QC systems developed and applied for HRD

Activities	**Responsibility**	**Risks and Assumptions**
outputs of the HRD system	MOH with support from ZHTIs	and informing HRD planning
HRD system informed by national/ Regional and international developments	MOH	Systems in place to inform HRD planning process of new developments in technology and delivery approaches.
Monitoring the functional and institutional performance of the HRD system	MOH with support from ZHTIs	Monitoring and Evaluation systems developed and applied and informing planning MOH have sufficient resources available to engage with regional and international health initiatives Capacity is built in the MOH to effectively utilise research findings and examples of best practice to strengthen health services delivery

Annex 2: legislation regulations and policies

	General Government	General Health	Specific Human Resources in Health	Other sectors or multisectoral
Policies	- Public Service Reforms Policy - Public Service Act - Public Service Management and Employment Policy - PRSP - MTEF	- National Health Policy - National Health Act (under revision) - Essential Health Package - Policies in HIV/AIDS, malaria, TB, etc.	- Policy for Development of Human Resources for Health -	- Education and Training Policy - Higher Education Policy - Technical Education and Training Policy
Reforms programmes	- Local Government Reforms Programmes	- Health Sector Reforms Programme - Hospitals Reforms Programme	-	- Reform of tertiary and higher education and technical and vocational training
Mid-term plans	-	- Health Sector Strategic Plan 2003-2008 -	- Human Resources for Health Plan 1996-2001 and successor	- Higher Education Sub-Sector Master Plan
Regulation systems	-	-	- Nurse and Midwives Registration Act 1997	- Institution of HEAC and NACTE

Annex 3 Budgets

(separate spreadsheets change programme and quick wins)